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## ORIGINAL ARTICLES.

### LOCOMOTOR ATAXIA.

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Locomotor ataxia is a disease due to a lesion of the sensory portion of the spinal cord, associated from its onset with disturbed action of the exodic system. It is a chronic disease, extending over a long period of years (from five to thirty), and is commonly divided into three stages. *First*, invasion; *second*, incoördination; *third*, stages of complications.

I would especially emphasize the fact of its long duration, as a case under my treatment for Bright's disease was diagnosed by a physician, called during my absence, as locomotor ataxia, though the whole duration of the sickness was less than a year. Prof. Erb, of Heidelberg, in Ziemssen's Cyclopædia of Medicine, says: "The duration of the disease is generally very considerable, and is always to be counted by years, and sometimes by decades." Cases may go on to the stage of incoördination in a few weeks; when the symptoms will abate or remain quiet for a long period.

The present name and the impulse to study the conditions of this disease were given by Duchenne, though for years, it had been known as *tabes dorsalis*.

When fully developed it is characterized by difficulty of walking; disturbed action of the bladder causing slow and difficult micturition; disordered action of the rectum causing constipation, with loss of visceral reflexes; followed, still further in time, by imperfect use of the upper extremities, and by impairment of the visual and auditory senses. Muscular power is not lost, but

because of imperfect coördination of the muscles the error of making a diagnosis of paralysis occurs.

The parts of the cord most commonly involved, are the columns of Gall and Burdach, the disease being confined, in the first stage, to the dorsal and lumbar regions. It is only when the cervical region becomes diseased that the upper extremities are affected, and the pupils become contracted and fail to respond to light.

There are severe pains of a lightning-like character,—compared by many to the insertion of a knife or sharp instrument into the flesh of the parts,—especially of the lower extremities. The stomach, rectum or bladder may be affected and, in the early stage, dyspepsia, hemorrhoids or stone in the bladder may be thought of. These pains are common in the first and second stages, and may be present in the third. Ataxia is differentiated from rheumatism or neuralgia by the pangs being momentary in duration and, unlike the pains of rheumatism, do not attack joints, cause swelling or stiffness, but attack small local areas, usually between joints, and are not often repeated in the same spot. Nor do they, as in neuralgia, follow the distribution of nerves, nor along nerve trunks, nor have sensitive points upon pressure along the course of the affected nerve.

Again the pains of neuralgia are referred to the skin, those of ataxia to the deeper structures. Also the latter are confined mostly to the lower extremities and ab-

dominal viscera, while neuralgia and rheumatism attack any part of the body. The skin is for a short time after the attack, tender over the spots of pain, but the most common sensation is that of anæsthesia,—a feeling as if the feet were in cold water; as if the soles of the feet were covered with mud or felt; a feeling of tingling, pins and needles, or as of insects creeping under the skin. The light touch of a pin, hair, or thread may not be felt, while there is pain upon firm pressure. Delayed conduction of sensation is one of the marked symptoms of this stage. The prick of a pin, which should be conveyed to the brain in health in about one twenty-third of a second (sensation traveling, as per Flint, eighty-seven feet per second), is perceptibly delayed. Gowers cites a case, in his practice, of sensation being delayed seven seconds; in another case (Eulenberg) a delay of fifteen seconds. In many cases the pain will increase for several seconds after being felt, and will last for several seconds after the exciting cause is removed.

After a period of a few months,—or it may be many years,—comes the stage of *incoördination of muscular movements*. These are usually manifested in the gait because, as before said, the lesion is, at this stage, in the lower segments of the cord. The loss of patella reflex and ankle-clonus is now marked, although in part absent from the onset of the disease. If the disease, at this stage, involve the cervical region, there will be incoördination of the upper extremities which can be tested by asking the patient to write or place their finger upon nose, eye or ear, or to button and unbutton their clothes. While the gait is labored there is no paralysis; the power of the individual muscle remains while the power for several muscles, or groups of muscles to act in harmony is lost. One of the first things a patient notices is the inability to put his feet upon small objects or to lift them to place them upon a stair, chair or stirrup. One patient I had, complained that he could not wash his face with his eyes shut.

After a time the patient will stand with the feet wide apart the better to keep the balance. Locomotion in the dark, or the hurried crossing of a street, causes a sense of insecurity—the visual sense being necessary to direct the movements. A cane now becomes

useful to preserve the balance. As incoördination increases, the power to stand with feet together, though the eyes be open, is lost. The patient now walks slowly, with determination and deliberation, with a jerky, stamping motion, the heel coming to the ground first. Movements of the legs are sometimes unexpected; the toes and foot are thrown outward, and the patient falls. The motion of the limbs in walking has been compared to the swinging motion of a tight-rope performer. The soles of the feet have become deprived of sensation, and the anæsthetic condition has extended upward along the legs and thighs which may become dead to all sensation. Dr. Ranney used to teach, and insist upon this fact emphatically, that the symptom thought (by so many physicians) to be pathognomonic of staxia,—staggering or falling when standing with eyes closed or upon walking backward, goes for naught unless joined with many other symptoms which are common; and that no test is more worthless for this special affection. A patient of his, whose feet were severely frozen, would fall because of the loss of sensation. And the condition of staggering or falling is found in hysterical paralysis, hysteria and myelitis of the posterior horns. A case of hysterical paralysis came under my notice two years since, which had been diagnosed as ataxia upon this symptom alone,—the patella reflex was present; lightning pains absent; sight and hearing abnormally acute. Intracranial diseases, such as Meniere's disease, or attacks of auditory vertigo, cause staggering. Hence, as in all cases of complicated disease, diagnosis by exclusion is the only true and safe way to reach conclusions.

A painful sensation, as of a rope or belt fastened tightly about the waist or body, is often present. This is called the *cincture feeling* and its location, in a measure, determines the parts of the cord involved; remembering, however, that the nerves, as they pass out of the vertebral canal below the first lumbar vertebra (the cord not extending lower than this), increase the length of their roots; the lumbar, sacral, and coccygeal nerves increasing from nerve to nerve by the thickness of a vertebra.

It is stated that in five-sixths of the cases where the eye is affected, the reflex action of the iris to light is lost.

Atrophy of the optic nerve is the most serious of the eye complications in tabes; of this complication, however, I know nothing.

There is also, in the third stage, vertigo and deafness. The functions of the other cranial nerves are not affected.

The complications are the causes of death,—ulcers; herpes; perforating sores of the foot; retained urine with ammoniacal decomposition; cystitis from use of catheter; fecal poisoning from retained feces; changes in nutrition of bones and joints. One case, which I have, has two large sores where his knees rub together, and he is obliged to keep them apart by cushions. There is sometimes vomiting in the gastric crises, of the peculiar expulsive character seen in brain troubles,—without warning and without nausea. Bed-sores, urinary troubles, and passive pneumonia in bed-ridden subjects, are frequent causes of death. As syphilis is one of the common causes of the disease, gummata, or syphilitic disease of cerebral vessels causing apoplexy, may occur. The disease itself is not fatal, many patients remaining bed-ridden for a long period of years.

Eichorst gives, in tabulated form, the more important symptoms, quoting the following authorities:

	Bernhart. 58 cases	Erb. 46 cases
Absence of patella-reflex	100.0 per ct.	98.0 per ct.
Lancinating pains	79.5 "	92.5 "
Paresis of bladder	74.1 "	81.0 "
Delayed conduction of pain	84.4 "	89.5 "
Feeling of exhaustion	92.0 "	97.9 "
Ataxia	94.1 "	100.0 "
Sexual Weakness	43.7 "	78.5 "
Swaying and tottering with closed eyes	90.2 "	83.5 "

*Pathological Anatomy* shows sclerosis of the whole posterior column. This explains the cause of delayed sensation, the sclerosis causing such pressure upon the sensory nerve filaments as to partially or completely destroy the axis cylinders.

*Etiology.*—Ataxia is found more frequently in city than in country life; in families of a neurotic tendency, manifesting such diseases as insanity, epilepsy, and degeneration of the nervous system. Exposure to cold and dampness, traumatism of spine, sexual excesses, syphilis, and some acute blood diseases are accredited causes.

There is quite a difference of opinion as to syphilis being a cause. Some contend that, if it were a factor, no particular part

of the cord would be singled out, but any, or all parts would be affected alike; also, that the most energetic antisymphilitic treatment does not effect a cure, while it usually cures in paralysis from brain lesions of syphilis. Others contend that it is one of the most common causes. Hutchinson, the great English authority on syphilis, in a recent lecture, says:—"There are certain affections which appear to be related to syphilis, although not directly dependent upon it, in which it is a predisposing, though scarcely an efficient, cause. Among these I count locomotor ataxia and paralysis of the insane. We seldom see ataxia excepting in those who have had syphilis." Gowers cites fifty consecutive cases in which twenty-nine, or fifty-eight per cent. had definite histories of syphilis.

Men are more prone than women to ataxia, in the proportion of ten to one, showing something in the sex predisposes to it. Possibly due to a man's occupations; to exposure; to cold and dampness; to drink and sexual excesses; as, also, to accidents which harm the spine. It sometimes follows acute blood diseases, inflammatory rheumatism, etc. It is a disease of middle life, rarely occurring during childhood or after the fiftieth year of age.

*Prognosis.*—Gowers, Ranney, Horsley, and Hamilton claim that some cases can be cured, and we know the great majority can be relieved by proper treatment. If it prove fatal, it is from some intercurrent affection. The duration of the disease is undefined. Sometimes the second stage is never reached, but even with complications some cases last from five to thirty years.

*Treatment.*—In the first stage, if we are consulted, we should remove all known causes, such as excessive mental work, anxiety and physical fatigue, since they are harmful; and we should insist upon perfect rest. Care should be taken to avoid anything tending to depress the nervous system. If exercise be taken, it should be short of fatigue. Care should be taken to avoid jolting or concussion of the spine. Cold is very injurious, and exposure to a chill results in a rapid increase of the disease. In a medicinal way the digestion and bowels should be attended to. One of the best known remedies to aid digestion and assist the free action of the bowels and kidneys, is the

free use, one and one-half hours before eating, of from one to two glasses of hot water. It causes peristaltic action of the bowels, washes out the stomach, increases the flow of urine and the action of the skin, and soothes the terminal filaments of the nerves of the stomach. The water must be as hot as can be borne. Ergot, one drachm three times a day, combined with some of the bromides most easily taken; citrate of lithia, and, most important of all, the actual cautery, are valuable remedies. Total arrest of the disease and of pain has followed the last named procedure. When there is intense pain, hypodermic injections of morphine or the internal use of Codeine, are of service. In the second stage the bromide should be stopped. Should there be the least history or suspicion of syphilis, the mercury and chalk mixture, (which, Hutchinson

says, "is the only form in which to use mercury for a long time"), which we also use in the first stage, should be continued. Nitrate of silver in pill form can be used, not pushing it, however, to the extent of staining the skin. Static electricity, cautery, and, if the bladder be affected, belladonna should be used. Hammond advises the injection of atropia. Suspension, causing separation of the vertebrae, is highly recommended, but the results have not proved as beneficial as at first reported. If there be any retained urine, the catheter should be used. The bladder should be washed out with a fountain syringe and soft catheter, which the patient can be easily taught to use. Arsenic is a very valuable remedy; used best in the form of Fowler's solution. Bed-sores and all other complications should be watched for and treated as they arise.

## CLINICAL LECTURES.

### TUBERCULOSIS OF THE SHOULDER JOINT; TONSILLOTOMY; TUBERCULOSIS OF THE HIP JOINT.

JOHN B. HAMILTON, M. D., LL.D., CHICAGO.\*

#### TUBERCULOSIS OF THE SHOULDER JOINT : RESECTION BY A NEW METHOD : TEMPORARY RESECTION OF THE ACROMION.

Gentlemen : The first case that I shall present to you to-day is one of tuberculosis of the shoulder joint.

Tuberculosis comes to this clinic so often that it is hardly worth while for me to go into the details of the pathology of the affection further than to say, that it constitutes, roughly speaking, about ten times as many cases of disease in this clinic as come from any other single cause—that is in the form of tuberculosis of bones, joints, glands, or some portion of the body.

In the case of the patient before us we have a sinus on the anterior border of the axilla, and another one posterior to the axilla at its outer border; each of them extending directly upwards for three and a half to four inches on either side of the

humerus. I cannot pass a probe directly into the shoulder joint, and yet I have no doubt that the pus in this case proceeds from the shoulder joint. This man seems generally sound, but we notice atrophy of the muscles of the arm. The right arm itself is helpless as compared with its fellow. And for nine years the patient has had these two openings, at times closing, at others breaking out and an abundance of pus being discharged through these fistulous tracts.

It can be but one thing. We might have, it is true, a foreign body, such as a projectile from a pistol, or a gun-shot wound in the head of this bone, but the history of the case shows there has been nothing of that kind. He states that about nine years ago he received a bruise on the shoulder over the deltoid muscle. But there is no apparent connection between that bruise and the existing sore, except sometimes we know that tuberculosis which is latent, is suddenly lit up, propagated and developed by mechanical

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violence, or is produced by irritation of some sort,

We are confronted with the problem to-day, how best to stop this constant drain of the system without seriously impairing the joint. On examination I find he is able to raise a chair with his hand. He can raise the elbow nearly to a level with the shoulder but the arm is disabled almost totally. We must plan an operation in this case which will not deprive him of the use of the arm, at the same time we must destroy the pyogenic center.

I propose then to make an exploratory operation. I shall cut down by the method proposed by my colleague, Prof. Senn, in his recent work on "Tuberculosis of Bones and Joints," making a temporary resection of the acromion. So far as I know, no surgeon has as yet performed it. We will test its feasibility at this time; make the operation, and expose the portion of the joint surface that is the probable seat of the disease.

In making a resection of the head of the femur, we take a chisel, lift up the trochanter, leaving its muscular attachment, so that when we cut off the head of the femur we can then return the trochanter and the rotation of the limb is perfect when the trochanter again unites. I have a patient, at present under observation in the Presbyterian Hospital, who can turn his toes in and out as well as he could before the head of the femur was removed. That is accomplished by preserving the muscles intact, making a temporary resection. We do the same thing in the case of the olecranon and other bones.

I shall, in this case, make a straight incision, commencing just above the acromion process, extending through the skin, passing a little backward toward the posterior border of the axilla. I shall then meet that with another incision, passing down toward the spine of the scapula. In this way I propose to fully expose the acromion process, and then make a temporary resection of that process. This should expose the capsule of the joint with the least injury to the soft parts.

Several methods of opening this joint have been proposed and practiced. There are perhaps ten or fifteen different lines of incision. All of them are planned to avoid the great vessels of the axilla; some are made on the anterior surface; some directly through the deltoid on the external surface.

I shall first locate the acromion. Locating it, we make a transverse incision just above it and then a long one just behind the acromion, passing down along the external border of the deltoid muscle. You will notice that the probe on the anterior surface passes directly upward for a distance of three and a half to four inches; there is another opening on the posterior border which passes in the same direction. So the inference is clear that the source of origin of this pus may be the shoulder joint. Please remember, that in this operation it is not proposed to detach the muscle from the bone. On the contrary we propose to preserve its bony attachment.

I now with the chisel cut through the acromion process, and you will see that the attachment of the deltoid is practically untouched. Theoretically we shall be able to come directly upon the capsular ligament and, as you will see, we shall be able to enter the joint from above. Observe that the pus cavity is directly under the acromion in this case and that I have now come upon the capsule of the joint. I shall open it and pass my finger over the joint surfaces. I must be careful, in opening the joint, not to interfere with the long tendon of the biceps, or the circumflex nerve. In order to prevent that we shall determine where the biceps is located in its groove and, in order to throw it out of its position so far as may be, we will rotate, bring the humerus across the body and enlarge the incision. The portion of bone which you see is the acromion process of the scapula which I have turned up. The pus cavity I uncover when I lift the acromion. We probably do not see the extent of the carious process, so before proceeding to the more radical method of turning the head of the bone out, I will remove the pus. The difficulty attending this operation so far seems to be lack of room to fully expose the head of the bone. I will increase the room by further turning up the deltoid flap. We are now breaking into pus cavities all about this joint. The head of the humerus is now well uncovered, or rather the external face of it is. We will separate the attachments from the glenoid cavity by throwing the arm directly across the body, then making rotation outward. The bicipital groove is now exposed to view. I shall cut the fascia and the tendon sheath so as to loosen the biceps along the groove and not cut it,

for by so doing the circumflex nerve should be thrown over with it.

Pus comes directly out of the bone the minute the chisel strikes it. We have to deal then with a case of tubercular osteomyelitis of the head of the humerus. The bone is very soft. The head of the humerus is honeycombed with pus, and so soft that the slightest touch suffices to break it down. You will see that the exposure of the joint has been perfect. Prof. Senn's theory has been carried into practice here with success so far as reaching the joint is concerned, which, of course, is the main thing.

I have now scraped out the carious bone, removed the head of the humerus and shall smooth the glenoid cavity, which seems to have been infected, pack it with iodoform gauze and then clean it out. First rub it well so as to have the iodoform fully penetrate it. Fill these surfaces with iodoform powder, so that any tubercular deposit, which may have escaped being scraped out, shall be reached by it. I now take the soft parts that are involved in the disease and scrape the pyogenic surface so as to leave the tissues exposed to view. We will pack the cavity with iodoform gauze, carefully and tightly, and leave one end projecting at the most dependent portion of the wound, so that we can remove it at pleasure, and it will at the same time serve for drainage. I shall now tie the vessels if they seem to require it, which they do not, and then bring back the deltoid and suture the acromion section which was made. It is a temporary resection. The deltoid is preserved.

This man will be able, hereafter, to raise the arm precisely as he could before the operation, which is the particular point to be gained by a temporary resection of the acromion. I passed the needle through the fascia covering the bone and through the periosteum on each side of the incision, so we are bound to bring the acromial surfaces directly in apposition. If I had this operation to do over again, I should throw back the deltoid and dissect it off from the face of bone in the beginning. This would shorten the operation one-half.

On examination of the removed bone, we find that the pus originally came from the centre of the head of the humerus. You can see it as a pulpy mass, evidently tu-

berculosis of the humerus. The tissues immediately about were little involved except that they afforded depots and an outlet for the pus. At the point where the drainage is inserted I shall put in temporary sutures, leaving a long loop so that they may be tightened subsequently, constituting what is termed secondary sutures. I shall now complete the operation by passing a small-sized sharp spoon into each of these original openings and scrape out the fistulous tract. The upper end of it was thoroughly done when the flap was turned up. I am satisfied that this operation will be one of the most common for reaching the joint. It is very easy of performance, and I believe it will be found to be more successful than others. The wound is to be thoroughly cleansed; the arm fixed to the side; cotton and gauze placed next to it, and then by a plaster-of-Paris roller the shoulder is fixed in position for three weeks. We may cut a fenester in the plaster if we find a rise in temperature, but if there be no elevation of temperature the first dressing will remain for a period of one week.

#### TONSILLOTOMY.

This child has a sore throat and a swollen tonsil. I have here the tonsillotome of Fahnestock. It consists in a ring with a double spear for fixing the tonsil and a guillotine blade which pushes through when the tonsil is fixed. It is intended for the partial removal of the gland when it becomes permanently hypertrophied. I think the surgeon is not justified in removing tonsils when swollen, and in a state of acute inflammation. But when they become permanently hypertrophied, and the condition has existed for some time, and there is no longer any probability that the gland will resume its normal size, then the surgeon is justified and should remove the projecting portion of the tonsil. I prefer in my office, when I am required to do the operation, to take a volsella forceps with the claws at the side, open the mouth, seize the tonsil, and cut it off with a curved bistoury—a more surgeon-like instrument than this machine I am now using.

#### TUBERCULOSIS OF THE HIP JOINT—TEMPORARY RESECTION OF THE TROCHANTER.

I have not recently examined this child and I do not know, therefore, what opera-

tion will be performed, but we will find out as soon as the examination is completed.

She has been in the hospital several times; sometimes having extension apparatus applied, at other times remaining in bed with weight and pulley. But all of that kind of treatment, which is simply palliative and intended to hold the joint surfaces apart while the child is under tonics and other means of treatment, has been without avail. She now comes back to the hospital unable to walk, unable to move the hip without severe pain—so painful in fact that I propose to conduct the examination under anæsthesia, perform whatever operation is required and can be done at this time.

On turning the child on the side you will notice a fistula posterior to, and a little below the trochanter. We will take the probe and ascertain the direction of the fistula. I find that the probe passes directly into the joint. There is, therefore, only one way to treat this joint successfully at this stage, that is, to make an opening into it, remove either the soft parts by arthrectomy, or resection of the bone, or both, according to the extent of the disease. If this girl were an adult instead of a child, there would be no objection to performing a typical resection, but in children an atypical one should be the rule.

I will content myself by cutting down upon and performing a temporary resection of the trochanter. We simply cut down upon it by linear incision, with the chisel lift it up with its muscular attachments, and the neck of the femur is fully exposed. We are then able to reach the joint. I make my incision directly over the trochanter, slightly curved, but passing deeply down to the bone. I have separated the soft parts from the bone as much as is required to make a linear incision to the trochanter. I have separated the trochanter from the femur with the chisel and the incision is directly on a level with the upper surface of the neck of the femur. I shall turn the trochanter directly upward, which gives complete access to the capsule of the joint. I now separate the neck of the femur from its attachments, open the capsule and expose the joint. Now, by rotating a little, I can put my finger directly into the opening and feel the amount of erosion that exists, with the head of the bone still within its

socket. If it be not too great, I prefer to do but little else than to make an opening into the joint and provide for the injection of iodoform.

Remember what I have previously said about resection in children. We avoid them whenever possible, as we stop the growth of bone by resection; whereas, if we can perform an arthrectomy, or, by gouging out the carious portions of the bone preserve the joint, we will have accomplished very much more for the child.

I find a sinus with a roughened surface on the face of the bone, and I shall gouge out this opening first, as the bone is quite soft. I shall be able to do it without using the knife. This is being done subperiosteally. I am passing a gouge longitudinally along the neck of the femur to the head of the bone, and removing the carious surface, which I will soon have complete access to, piece by piece. The pus, which is very plentiful here, exudes from the bone in several places, and we have, as in the shoulder case, evidence of its commencement in the medulla of the bone and its cancellous structure. I find that the acetabulum itself is involved, and the rim of the acetabulum will have to be scraped out. This I am doing. The process is tedious. In the removal of these fragments of bone you will find it expedient to use the finger as a guide, keeping it on the fragment while the instrument (the sharp spoon) is being fixed. In this way you avoid unnecessary damage to the soft parts, and it enables you to have control of the operation at nearly all of its stages. The specimen which I show you, as now removed, consists of half of the side of the neck of the femur and half of the head. You will see how the disease has progressed around the head of the bone. The white, glistening portion is the articular surface of the head of the femur; the eroded portion of the other side is where tuberculosis has eaten into the head of the bone. We now irrigate the joint as there is a great deal of eroded surface; the wound is dusted with iodoform powder, and, as before, iodoform gauze is inserted for drainage. There is a sinus underneath the bone in the soft parts extending into the cavity of the acetabulum, which I thoroughly scrape with the sharp spoon. I now bring the trochanter back into its place, leaving a drainage of gauze from the most dependent portion of the



wound which passes directly into the joint. We sew the trochanter into position with very heavy catgut. I pass a needle through the periosteum, the fascia and sheath of the muscles attached to the trochanter and through the same structures on the shaft of the femur, thus bringing the parts into perfect apposition. The power of rotation of this child's thigh when the trochanter and bone unite, which will be in about three weeks, will be as perfect as before the operation. Care should be taken that no tension is put upon the stitches that can be avoided. The limb should be fixed in a position which brings the bone together without tension. The packing, which is being inserted, is in the intermuscular septum where the pus formed during the progress of the disease, and which has been thoroughly scraped and irrigated. You will notice there has been very little hemorrhage. Hemorrhage is much less when the trochanter is resected than in the other operation.

The dressing in this case will be precisely as in the former one. The parts about the wound are to be well cleansed; iodoform gauze and antiseptic absorbent

cotton applied, and a plaster cast over all.

The history of these cases after resection of a joint, performed as these were, is generally one of uninterrupted convalescence. Occasionally we have a sinus formed directly in the tract of the wound, due, undoubtedly, to some pyogenic reformation,—some bacterial colonies which were left in some undisturbed pocket at the time of the operation. But in the majority of cases we do not expect any result other than steady progress toward uninterrupted convalescence. It is a crippled limb, but it was this before the operation was performed. We have stopped the pus formation. More than that, it differs from an ordinary resection in this particular: after the old methods of resection, the limb hung like a flail; while it might be as powerful as before, especially after resections of the head of the humerus, yet the power of rotation was completely lost; and in many instances the power of elevating of the elbow to the level of the shoulder was lost. In our case of temporary resection of the acromion, I have no doubt the power will be as perfect as before the operation.

## COMMUNICATIONS.

### TECHNIQUE OF SUPRA-PUBIC CYSTOTOMY.

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I would like to present as a basis for discussion, a few points relative to the technique of supra-pubic cystotomy. I have been impressed, in all of these operations that I have seen, with the importance not only of a strict regard for the indications to be met in each individual case, but also with the importance of a strict attention to detail in meeting them, if we would receive the greatest possible good from our operation.

Viewed from the standpoint of the technique, I think we can properly divide our cases into four general classes.

The *first* class includes the recent cases of stone and foreign bodies and small pedunculated growths, where the bladder is only moderately or not at all diseased.

The *second* class includes the neglected cases of the first class, where severe in-

flammatory changes have taken place in the bladder walls.

The *third* class includes the cases requiring removal of tumors or prostatic outgrowths, or prolonged drainage for cystitis.

The *fourth* includes that not inconsiderable number of old neglected strictures of the urethra in which a guide cannot be passed for the perineal operation, and retrograde catheterization of the urethra is desired.

In the first class, no especial preparatory treatment is requisite beyond emptying the bowels by laxatives and enemata, irrigating the bladder with boric acid solution and shaving and cleansing the abdomen.

The anæsthetic—preferably chloroform—being administered, an oval rubber bag with the tube attached is introduced into



the rectum. By means of a soft catheter and a hand syringe the bladder is filled with warm boric or Thiersch solution, the quantity being regulated by the known capacity of the bladder and the sense of resistance imparted to the hand; this is retained by an elastic band around the penis and a clamp on the catheter. The rectal bag is now slowly and carefully injected and the bladder may be felt in contact with the abdominal wall above the pubis. A three inch incision in the median line, just above the pubic bone, carried down between the recti and pyramidalis muscles exposes the prevesical space and the presenting bladder wall covered by a thin membrane containing more or less fat. This fat, which contains the peritoneum, is rolled up from the symphysis, care being taken not to disturb the lateral attachments of these loose tissues. This little manoeuvre is often much abused, and operators, in a frantic effort to avoid the peritoneum which is in no danger if the bladder and rectum have been properly injected, so loosen up the attachments behind the symphysis and around the neck of the bladder that urinary infiltration and consequent cellulitis is inevitable.

The bladder being exposed, any large veins on its surface in the line of proposed incision are ligated with fine catgut by means of a sharply curved needle; and a strong silk ligature is passed deeply into the wall of the bladder, which is incised just below by a clean thrust of the knife. This ligature serves to hold the bladder in contact with the abdominal wall after the incision, and diminishes the risk of tearing loose the anterior attachments while punching around in the bottom of the pelvis trying to find the opening in the now collapsed organ.

The incision in the bladder should be of sufficient length to permit of the easy removal of the foreign body without tearing and bruising the edges of the cut. Guided by the ligature the finger is quickly introduced and the body removed. After thorough irrigation the bladder, being still held up and steadied by the ligature, is closed with numerous interrupted sutures of over prepared catgut carried down to the mucous coat; or in some cases, an oval surface may be denuded around the incision and the broad, fresh surface thus formed united by two rows of continuous suture. A small drainage tube is

laid over the line of suture and brought out of the lower end of the external wound, which is closed down to this point. A soft catheter introduced through the urethra and tied in, completes the operation.

In the second class, with inflamed, contracted bladders, effort should be made to cleanse them and at the same time gradually dilate them to a reasonable capacity before operation, and unusual care should be taken against rupture when the final distension is made under anæsthesia. The operation is completed as in the former class up to the point of closing the bladder wound.

It being evident that the wound of an acutely inflamed and contracted bladder will not unite primarily no attempt should be made at closure, but drainage should be free. This may be done by a tube carried to the bottom of the bladder and retained by fastening to the skin, or by a perforated hard rubber plate with straps carried around the abdomen. The end of this tube may be left long and drain into a vessel at the bed side. If the tube causes much pain and is forced out it is often impossible to replace it; this seems to be of little moment as far as the bladder is concerned, as it will drain and can be thoroughly irrigated without it, but the patient is kept continually wet by the flow of urine.

In the removal of tumors or prostatic outgrowths from the bladder by the suprapubic method, the rectal bag should be distended as far as safety will permit, thus forcing up the base of the bladder and greatly facilitating the work.

The Trendelenburg position is also of great service here, bringing the parts well into view. After the removal of these growths there always arises the necessity for thorough drainage for a considerable length of time, and, in the case of old cystitis, the drainage may have to be permanent. This drainage, in my experience, cannot be well accomplished without fastening the bladder to the abdominal wall. The tube almost invariably slips out, or has to be removed on account of clogging or becoming encrusted with urinary salts, and it is often impossible to replace it through the long sinus running down to the bladder. This sinus contracts rapidly and, unless the obstruction at the bladder neck has been perfectly removed,

the cystitis will return, and not only will there be no benefit derived from the operation, but a small discharging sinus will add misery to an already miserable being.

In opening the bladder for retrograde catheterization of the urethra in impermeable stricture the rectal bag should not be used. The bladder is usually diseased and

distended and the danger of rupture is great. A little care in stripping up the prevesical fat is all that is needed to avoid the peritoneum. The opening should be small and, as a rule, immediate suture practised, free drainage being kept up through the perineal opening until union is complete.

### NURSING IN TYPHOID FEVER.

JOHN C. HOLMES, M. D., CRANBURY, N. J.

To the country physician the nursing of typhoid fever is of particular interest, as he so frequently has considerable difficulty in obtaining a competent nurse in fever cases.

There is no disease in which, during the entire course, every organ of the body is so liable to become disordered as in typhoid fever. Therefore good nursing and particular attention to all of the minor details is absolutely essential.

When a case of typhoid fever occurs in a family, the first step to be taken is to isolate the sick person as much as possible from the rest of the household; this is necessary for two reasons, first, for the comfort of the patient, and secondly, for the safety of the other members of the family.

A large room should be selected, and one which will afford means of perfect ventilation.

The windows should be raised about four inches, and a board fitted tightly at the bottom, thus giving a free access of air over the top of the lower sash, and avoiding all draft.

This ventilation should be continued day and night, even in the coldest weather. A uniform temperature should be maintained from 60° to 70° F.

In winter an open fire place or grate is to be preferred to any other method of heating a sick room. Let the patient have as much covering on the bed as is necessary, but keep up the free ventilation at all seasons of the year; fever patients are not liable to take cold.

Do not admit visitors at any time during the course of fever—mental quiet is as necessary as bodily rest. Remove all carpets and curtains—in fact all that is required in a "typhoid room" is the bed,

one chair, a small table and an alcohol lamp. Have a large covered clothes basket in an adjoining room, in which all soiled linen may be at once placed and immediately carried out of doors; wash these clothes separately from the clothing of others, and direct the wash water to be emptied at a safe distance from the house and well.

The sheets should be changed every day, and this can be done easily by folding the under sheet close to the patient, spreading one side of the bed over, and then gently lifting the person over on the clean side, at the same time removing the soiled and smoothing out the clean sheet.

The aphorism, "cleanliness is next to godliness," is indeed truly hippocratic, and most assuredly applicable in typhoid fever.

Twice a day wash the face, hands and limbs and, if advisable, even the entire body with lukewarm water to which add a little alcohol; in cases of extreme depression, alcohol or whiskey may be used alone; a sheep's wool sponge is the best for use in washing the body of a sick person.

All excretions from a fever patient should be received in a previously disinfected vessel and at once removed out of doors, at least one hundred yards from the well and house, and there buried—a fresh layer of sand spread over each time.

Now in regard to disinfectants, avoid carbolic acid on account of the unpleasant odor and the tendency to nauseate the sick. Platt's chlorides is one of the very best disinfectants; it is perfectly odorless and can be procured at a very reasonable price. Chloride of lime, used according to the printed direction on the box, is always good. A solution of copperas can be used to wash out all vessels which receive the

excrement, and it is a good plan to leave some of this solution in the urinal and bed-pan after they have been cleansed and returned to the sick room.

As to light—do not keep a sick room in darkness (unless there should be brain complications) in fever or any other disease—light and sunshine are as essential to the sick as to the well.

If a lamp is used at night, do not turn the wick down, on account of the gas which will be sure to be thrown off, but shade the light so that it will not disturb the patient.

One of the worst torments of fever is thirst, therefore give plenty of cold water; little at a time but frequently. A swallow of water will moisten the mouth just as well as will a glassful.

Drink should be given even when it is not asked for, as fever patients need just as much, and sometimes even more than when in health. Mineral water, lemonade and thin barley water are all exceedingly grateful.

Keep ice in a covered vessel wrapped in a woollen cloth and in the next room, and always break the ice with a pin. If coal is used for fuel, put it in paper bags, and place it on the grate—thus you avoid a noise which is sure to attract the attention of the sick.

Never attempt to use any force, or even to argue with a fever patient in order to have one take either food or medicine; the sick are frequently very unreasonable, and if the mind is disordered it is worse than useless to endeavor to reason with them. When anything is refused put it aside at once and appear to be perfectly satisfied. In five minutes offer it again, and nine times out of ten it will be taken without any complaint.

Never say to the sick, "now it is time to take your medicine," or "will you take the medicine now?"—do not use the word medicine. Prepare it in silence, take it to the bedside, and say, gently but firmly, "swallow this please." It is not to be wondered at, that invalids have a feeling of disgust come over them when they hear the rattling of spoons and see the nurse making elaborate preparations for the advent of each dose of medicine. I have seen the patient vomit at the sight of the glass and the noise of the spoon.

Always remember that a sick person can

never be spoken to too kindly; typhoid fever patients are frequently in a dreamy state of partial consciousness from which a harsh word would arouse them to the wildest frenzy.

The nurse should be a veritable sphinx as far as all conversation is concerned. Questions should be answered in a monosyllable, without any remark or comment.

Always pretend to remove any imaginary thing from the room if so requested by the patient; never declare that "it is nothing"; you can not convince one with a disordered brain that an hallucination is only imagination.

Nourishment should be given at regular intervals, and the physician should not only give explicit directions as to the kind and quantity, but should make out a "time table" for both medicine and diet.

The patient should never be allowed to have anything to eat or drink without the permission of the doctor. There is no disease in which the slightest indiscretion in regard to diet may prove so suddenly fatal as in typhoid fever—it requires but little to turn an almost evenly balanced scale one way or the other.

Do not allow the patient to rise for any purpose whatever from the beginning of the disease until convalescent; many fatal cases of syncope have occurred upon assuming an upright position even for but a moment.

Watch fever patients closely; never leave them alone—many apparently perfectly manageable cases have jumped from a window, or committed suicide when left alone for a few moments by the nurse.

It is best always to have two nurses, one by day and one for the night. Never trust the nursing to kind friends or good neighbors—who, while they may be overflowing with sympathy, have not the routine of the case, and therefore can not do as well as a regular attendant.

I have had seven cases of typhoid fever where I have found a new nurse on duty almost every day, and have frequently been unable to ascertain the exact condition of the patient during the night, as the nurse "had gone home to get a little sleep," and left no other report of the case than this, "they were about the same as usual."

If milk is used, keep it outside of the sick-room until it is required; never allow milk to stand in a typhoid room of all



others; prepare the exact quantity needed and use it at once—this direction should also apply to all meat-broths.

Do not tell a fever patient any unpleasant news,—give them to understand that everything is going along nicely.

Always speak encouragingly and hopefully, giving the sick the benefit of every doubt. There is no disease in which a person can sink so low, to the very border and in the shadow of the grave, and still recover.

Never "give up" a fever case, as changes for the better may occur when least expected, and even under the most unfavorable circumstances. I have seen cases which I feared would not live six hours, and have had the satisfaction of seeing them recover. Avoid all those people who make a business of "*nussin*," they believe they know it all and are far more liable to overdo matters than really

to neglect. Secure an intelligent man or woman,—one who has either an established reputation or a diploma from a training-school.

Good nursing is, indeed, the *sine qua non* in typhoid fever—without it medicine is of little value. I would prefer an intelligent nurse and no medicine whatever, rather than the attendance of an entire faculty and an ignorant or careless nurse.

Human life is far too precious to trust in the hands of unskilled persons; to err at such times is but too frequently fatal, and oftentimes the cause of life-long regret, which, while it may be without true cause, nevertheless may leave the unpleasant thought that perhaps something was left undone.

The constant attention to all of the *little things* always gives the best results in nursing.

#### A CASE OF CEREBRAL SURGERY.

W. C. DUGAN, M. D., LOUISVILLE, KY.

I have a case of cerebral surgery that I would like to mention. A lady about fifty years of age has had great pain in the head for eight or ten months, and it has steadily increased. She has been treated by a number of physicians on various lines and she has grown steadily and rather rapidly worse. Her hearing was at first but slightly involved, but latterly to such an extent that she could hardly hear at all. During the last few weeks I am confident there has been marked impairment of intellect.

I saw her for the first time several months ago, and then did not see her again for about two months; meantime her physician asked Dr. Dabney to make an examination, and he reported double-choked disk, the right more marked than the left. Later she had partial paralysis of the right leg, twitching of the right side of the face and incomplete loss of sensation of the right arm.

Diagnosis of tumor was made, its most probable location being in the left side about the upper part of the fissure of Rolando. She had two convulsions during this time, whether unilateral or bilateral I am unable to say, but they were

rather severe and were followed by considerable stupor. Exploratory operation was advised for the purpose of finding the tumor, the understanding being if it could be removed it would be done.

A very large semi-circular incision was made over the left parietal bone, the flap turned down leaving the periosteum intact. After going through the periosteum and turning it back separately, we took a large sized trephine expecting to take out a large button, but found it slow work, the skull being very thick. I then decided to take out a smaller sized button. The bone was removed and the membrane bulged up almost half way through the skull, very tense and feeling almost like wood. I then took a chisel and mallet and cut out the entire two inches of bone, the size of the original trephine. The tension was so great that the membranes came up almost on a level with the outer part of the skull. The dura was then incised and to my very great surprise,—and perhaps I should say my chagrin,—the brain just swelled up, almost like quicksilver, through the incision in the dura. There was a mass of cerebral tissue as large and thick as your finger pressed through the



opening in the dura, and the constriction was so great, and the tension from within so much, that it produced intense engorgement. The dilemma was not one to be envied, I assure you. I did not know how to close the dura. Knowing that there must be something to account for the great pressure, I explored with a hypodermic needle and found no fluid. I then took a groove director and passed it down to the ventricle, and found a large quantity of fluid in the left cavity—at least three ounces, and perhaps more. As the fluid flowed through the groove, the brain settled back in its place, and at the conclusion of the aspiration I was able to pass my finger around the dura, palpating the brain so as to ascertain whether there was a tumor anywhere. No tumor was discovered. I then thought best to pass the groove director through the septum to the other ventricle to see if any fluid existed there. This was carefully done, but no fluid found. The dura was then closed, and the scalp sutured, no drainage being used, and the patient dressed and put to bed. She reacted well from the operation, there being no shock.

She has had some little trouble since with loss of speech, but she is able to articulate some sounds distinctly and intelligently. She has suffered very little pain since the operation, and has been doing very well. Instead of finding a tumor we discovered an accumulation of fluid in the left ventricle, the pathology of which I am unable to give. The fluid seemed to be perfectly clear, but whether

it was tubercular or otherwise I am unable to say. The future of the case is purely one of conjecture; I am not prepared to say what the outcome will be. Her physical condition is good; the operation was done one week ago, and she sat up to-night and is suffering no pain. The paralysis has been relieved, but her hearing has not returned. I cannot help believing that the trouble will return and that the end is not very far off.

The paralysis was relieved immediately after the operation. Sensation now seems to be hyperesthetic. Before the operation, as she could not hear, her family would write messages on paper and she would look at it for a long time and eventually she would understand it. She would wait four or five minutes before answering a question, showing that her intellect was greatly impaired.

I left the bone out for two reasons: First, it could not have been replaced, as, after taking out the button with the trephine, the opening was considerably enlarged with the chisel; further I would have left the button out anyway so as to have the advantage of that amount of lack of resistance, and, in event of the fluid re-accumulating it can be aspirated with less trouble. The opening left in the skull, as nearly as I can judge, was about two inches in diameter. The only hemorrhage experienced was from separation of the dura. If I had not explored the brain, I would never have been able to have brought the dura together.

#### LIGATION OF THE ANTERIOR TIBIAL ARTERY ABOVE THE ANKLE JOINT.

A. O. STIMPSON, M. D., C. M., THOMPSON, PA.

Frank Allen, aged about thirty-three years, while chopping in the woods on the 9th of December, 1892, accidentally made a deep cut with an axe in his right leg, about one and one-half inches above the ankle joint, and on the outer side of the leg. The cut was apparently not a severe one, the incision being only about one and one-half inches long. He had on at the time a pair of felt boots (such as choppers and woodmen generally wear) and the axe, which was broad bitted with angular cor-

ners, having a very thin and sharp edge penetrated the flesh much deeper than one would naturally suppose.

After the accident his companions got him to the house as soon as possible, and resorted to ordinary domestic means to arrest the hemorrhage, by bandaging and the use of "puff-balls" as a local styptic.

No further difficulty was experienced with the wound until the next evening, when it commenced to bleed profusely.

I immediately applied the rubber tourniquet over the popliteal space, using as a compress a rubber "anti rattler" for wagon shafts. This controlled the hemorrhage completely. I then tied the injured artery (anterior tibial) with an iron dyed silk ligature. But the operation, having been done by lamp light, was not a success. On December 11th (at night again), a messenger came for me in great haste, saying that "Frank was bleeding to death." I hurried to the house and found that he had indeed lost so much blood that he was very weak. I immediately applied the tourniquet in the groin. This checked the bleeding at once, but I concluded then I would wait until daylight before ligaturing the wounded artery.

As soon as there was light enough, with the aid of a neighbor, I enlarged the incision upward toward the knee, and with a No. 11 iron dyed silk ligature I tied the artery the second time, using a sailors knot to prevent the loop from slipping.

I had no trouble from hemorrhage after that, but a wound remained that could only heal by second intention, or by granulation. In treating the granulating surface I used iodoform gauze, dry calomel and campho-phenique.

#### A Short Umbilical Cord.

J. B. CARRELL, M. D., HATBORO, PA.

On Dec. 28th, 1892, I delivered a woman, æt 38, of her fifth child. There was nothing unusual about the case until I attempted to move the infant from its moorings.

The child was drawn so closely to its mother that it was difficult to tie the cord; in fact the second ligature was applied by pushing up the external genitals. When the cord was cut it disappeared up the vagina. I could not wrap the cord about my finger to make traction on account of its being too short; so I effected removal of the placenta, which had been expelled into the vagina with the expulsion of the child, by hooking my finger into the body of placenta and making external pressure with the other hand. Upon examination I found a cord seven and one-half inches long.

This is not the shortest cord on record. The shortest I find mentioned was two

inches. Cazeau and Tarnier say: "The cord varies greatly in length at term; generally it is from twenty-one to twenty-three inches; some have been observed, however, from six inches to five feet; others, still more rare have reached five feet nine inches in length. I delivered a woman with the forceps, June 23rd, 1841, in whom the head had been retained above the superior strait, and where the cord was only nine inches long. These extremes are very rare; nevertheless, they are not the utmost varieties the cord may offer in its extreme limits, for it has been known not to exceed five inches, and has even been as short as two inches." With the expulsion of the child the placenta was expelled from the uterus into the vagina. Had such not been the case, the short cord would have interfered with the delivery of the child.

An exchange says that a new and simple method of preventing bed-wetting by children is proposed by Dr. Von Trenton, who simply raises the foot of the bed so that the child lies on an incline with the opening of the bladder uppermost. This is based upon the theory that the urine escapes from the bladder while the child is asleep. The remedy is simple and worth trying; the only difficulty is that most children have a natural fancy for rolling about in bed and will cause themselves to sleep with the head at the elevated end of the bed as often as otherwise. —*N. West Lan.*

Sugar in the urine is no more a proof of diabetes than albumen is of Bright's disease; and it is a great mistake to base the diagnosis upon the one point alone. The presence of the sugar may be due to transient nervous conditions, to temporarily defective action of the liver, to excess of sugar in the diet, as when a new clerk goes into a candy shop, or to a disturbance of the general system like that caused by the retention of the milk in woman who have suddenly stopped nursing. Gout, syphilis, heredity and renal disease may also cause glycosuria without diabetes. Ord, of London, says that while he has not frequently met with carbuncle or phthisis in glycosuria, they are common in true diabetes. —*North Lan.*

## SOCIETY REPORTS.

## THE SURGICAL SOCIETY OF LOUISVILLE.

*Stated Meeting of December 12, 1892.*

THE PRESIDENT, Dr. A. M. Cartledge, in the Chair.

DR. W. C. DUGAN reported "A Case of Cerebral Surgery" (Page 130).

## TWO CASES OF STERILITY FOLLOWING GONORRHOEA.

DR. E. R. PALMER: A young man, having been married three years, came to me a year ago with gleet and stricture of the urethra, with the statement that his wife was barren; that he wanted to be cured; that his wife also had trouble which he believed she had contracted from him, and that he wanted me to treat her also.

I operated on him for stricture by the Otis' operation, treating him for a long time and, at the same time treating his wife, who had chronic vaginitis and chronic endo-cervicitis with a deflected, fixed uterus,—a condition that we nearly always find where a woman had contracted gonorrhoea and the deeper membranes had been invaded.

This man was entirely cured of his gleet and stricture. His wife was very promptly relieved, her vaginitis disappeared, the discharge from the uterus ceased and she was in excellent condition. I saw the gentleman a few days ago, and he said he was happy to report that he was the father of a fine girl.

No. 2. About six months ago, when the pregnancy of the patient above referred to was well assured, another man employed by the same corporation, came to my office with his wife and asked me to make an examination, try to determine why his wife never had any children, and treat her for barrenness. I told him this was rather out of my line, and suggested his consulting another physician. He said he had been married two years, and his wife had never conceived. As I had treated Mr. and Mrs. So and So, who had been married three years and the wife was pregnant, he wanted me to see what could be done in his case. I made inquiries as to whether either of them had ever had any trouble of a venereal nature, and he replied that

they had not. I took them both over to Dr. Anderson's office and they were examined separately.

The woman was a magnificent specimen of womanhood, weighing about 150 pounds, apparently in perfect health, vagina and womb normal in position and size. In other words her entire sexual apparatus was in a perfectly normal condition.

I then took the man into an adjoining room and he confidentially gave me the history that several years ago he had contracted gonorrhoea with double epididymitis, but stated that he had been cured for a long time before marrying. I instructed him to have connection with his wife and bring me some of the semen for examination. He did so and it was found to be utterly devoid of spermatozoa, proving beyond all question why his wife had never become pregnant.

It is stated that in ten cases of barrenness the woman is at fault seven times, the man three.

DR. JAS. S. CHENOWETH read an essay THE TECHNIQUE OF SUPRA-PUBIC CYSTOTOMY (Page 126).

## DISCUSSION.

DR. W. O. ROBERTS: I have had considerable experience in the operation of supra-pubic cystotomy for stone, for cystitis, for tumor and for draining the bladder in old cases of enlarged prostate. In some cases I have used the bag and in others operated without it. I believe that we can get along just as well without as with it. Where we want to operate on the prostate, I think we can be better aided by an assistant introducing his finger into the rectum and pushing the prostate upward and forward, than with the bag. I have never found it necessary to tie any vessels in the bladder wound. As soon as the bladder is emptied, distension of the vessels will disappear and the hemorrhage will cease. I reported, I think to this Society, some time ago a very interesting case, a patient of Dr. Palmer's, where I operated for tumor of the bladder by the



supra-pubic method. The tumor in this case obstructed the flow of urine through the urethra; after closure of the supra-pubic wound the man was able to pass water by the urethra, throwing it three feet from him. This is not the usual result in such cases. As a rule they do not recover the power of completely emptying the bladder through the urethra.

DR. E. R. PALMER: I am forced to believe that the modern operation of supra-pubic cystotomy will eventually find its proper place to be where it has been fully determined that the old-fashioned operation through the perineum is not admissible.

With reference to the case just spoken of by Dr. Roberts, I believe that probably the perineal operation with curetting would have relieved the man with less after trouble. I believe that in the majority of cases where operations of this sort are done on the bladder, the tone of the bladder is so permanently destroyed that we cannot expect to restore the normal action of this organ through the natural passages. In the case Dr. Roberts has spoken of the result was all that could be desired, but I was impressed in that case, as I have been in a number of others I have witnessed, that if any man thinks it is a comparatively simple operation to go into the bladder above the pubes, he is the worst fooled man that ever took a knife in his hand. It has impressed me as being one of the most tedious, difficult and deceiving operations that a man can attempt. For my own part I do not expect to do, in my particular line of work, a great deal of this form of surgery; but, when I do it, my own preference is to go into the bladder where it is possible, through the perineum. I have no doubt that men with larger experience and with greater statistics to back them up than I am possessed of, are anxious, ready and hopeful in the matter of preference of supra-pubic cystotomy, notwithstanding the almost certainty of more or less permanent fistula which is one of the serious objections to the operation. I would always exclude the feasibility of operation through the perineum before resorting to supra-pubic cystotomy.

DR. W. C. DUGAN: I have enjoyed the paper and consider it a most excellent one in the main, but I cannot refrain from taking issue with Dr. Chenoweth in reference to the use of the rectal bag, also the

use of water in distending the bladder. In the first place I do not believe that the rectal bag is of any service whatsoever in supra-pubic cystotomy, and that if the rectal bag is indicated at all, it is after the bladder has been opened. It might be well enough to insert the bag if you are operating on the prostate; or on the base of the bladder; or for tumors where you want to bring the prostate up as high as possible. There is always danger of rupturing the bladder and rectum by distension and pressure from use of the rectal bag. I think it has been demonstrated beyond a doubt that we cannot elevate the fold of the peritoneum by distending the rectum with the rectal bag. You simply push the prostate and bladder up toward the symphysis. I do not believe the bladder should be distended until after we expose the prevesical fat; it being easier in my opinion to cut down upon an empty bladder rather than upon a full one. After you have made your incision, exposing the prevesical fat, have your syringe ready and let the assistant fill the bladder with fluid and you can feel the fold of the peritoneum slip under the finger. When this sensation is felt, then have the catheter tied around the penis and the bladder opened.

While supra-pubic cystotomy is attended with considerable danger I do not think the mortality should be over five per cent. in young, healthy subjects. In old men and in patients with chronic disease of the genito-urinary passages, it must necessarily be higher.

I think the doctor's precaution of suturing the bladder to the abdominal wall by a silk ligature is an admirable one and should not be overlooked. Suturing the bladder is a very important matter if we use silk. It is difficult to get the edges so accurately brought together that the ends of the suture will not fall through. I operated upon a patient some time ago and had this misfortune to follow. A piece of the suture material dropped into the bladder through the incision, around which a calculus formed requiring a second operation.

In regard to drainage: I believe in these cases there is nothing equal to iodoform gauze. I think it is better than a tube and gives the patient much less pain. It is necessary to be very careful to have your gauze well protected and all the little threads removed, wrapped with silk so



as to be doubly sure that you are not going to leave in any of the threads to cause the formation of calculi. I do not think the operation of supra-pubic cystotomy advisable in impermeable stricture of the urethra; I have yet to see a case that could not be relieved by simple operation either by external urethrotomy without a guide, or by the perineal method. I agree with Dr. Palmer that supra-pubic cystotomy is an operation of considerable magnitude, and was somewhat surprised to hear Dr. Hunter McGuire state, at the meeting of the Southern Surgical and Gynecological Society, that the operation was as simple as the opening of a boil; I am sure he made a mistake in that. At any rate it does not appear so to me. It is an operation which requires an accurate anatomical knowledge and perfect surgical technique.

DR. W. L. RODMAN: I am very much disposed to accept the steps of supra-pubic cystotomy as given by Dr. Chenoweth as being the proper ones. I believe that in the majority of cases it is better to use the rectal bag. It has been demonstrated that you lift the peritoneum and bladder higher by use of the bag than you can possibly do without it. I believe that the danger in using the rectal bag has been over estimated. It seems to me that it is a very weak bladder that is going to be ruptured by use of the rectal bag. I have always used the bag and shall continue to do so in every instance. Instead of ligatures I use two tenacula to bring the bladder well into view, and think this is the ideal way of lifting the bladder up into the abdominal wound. I do not like the use of ligatures for this purpose; they tear out and do more damage to the bladder wall than do tenacula properly used. Their introduction is also more tedious. I agree with Dr. Roberts in regard to hemorrhage; it nearly always ceases as soon as you have opened the bladder.

I further agree with the essayist in the position taken concerning supra-pubic cystotomy for so-called impermeable stricture. It occurs to me that supra-pubic cystotomy, while not an easy operation by any means, is both easier and safer than perineal section without a guide. I have a case now that I propose to do a supra-pubic cystotomy on next Wednesday or Thursday. It is a case of impermeable stricture that I have tried to enter twice and, rather than

do a perineal section without a guide, I shall perform supra-pubic cystotomy. I am very frank to say, however, that I have never in my life failed to get into the bladder through the urethra when the patient was put under chloroform. After putting the patient just mentioned under the influence of chloroform, if I fail to enter the bladder through the urethra, then the supra-pubic operation will be resorted to.

DR. H. H. GRANT: I was very much surprised to hear Dr. Dugan begin his discussion by stating that supra-pubic cystotomy was so simple as to be readily done without the use of any artificial means to raise the bladder up; afterward to state that the mortality was only five per cent, and then to criticise Dr. Hunter McGuire for teaching medical students concerning an operation as serious and grave as this one is. I think it is a very serious matter for surgeons of reputation and ability to educate young men to believe that any surgical operation can be done without great danger, or without considerable skill at the best to avoid this danger; that every means possible to make it easier and safer should be employed: and that no methods, which have received the approval and support of experienced and competent surgeons, should be discarded or condemned without some definite reason therefor.

I am firmly persuaded that in all operations of supra-pubic cystotomy that I have witnessed, and there have been quite a number, without the bag the peritoneum has appeared in the wound. I am also convinced that it is rarely seen where these means are employed.

A little difference is always to be found in the resistance of the tissues of the live and the dead body. The majority of experiments which have been employed to determine how far the peritoneum could be pushed up have been upon the dead body. Ability to push up the peritoneum and bladder by artificial means experience has shown to be very considerable, and, in many cases, the peritoneum has been found to be pushed three inches above the pubis—so far that there is no possibility of injuring it in the first incision—and easily pressed out of the way by the finger without any fear of wounding it. Certainly no danger can be experienced in distending the rectum with eight ounces of fluid in a rubber bag. When the plane which sup-

ports the prostate and the rectal base of the bladder has been raised toward the level of the pubic arch by distension of the rectum, the peritoneum will be proportionately higher as a matter of simple mechanics, and when the bladder is afterward filled with the solution the fold of peritoneum rises much more readily.

DR. W. C. DUGAN: Right at this point I would like to ask the speaker if he believes that eight ounces of fluid in a rubber bag will lift the bladder up three inches?

DR. H. H. GRANT: I have already stated that in all the operations I have seen, and there have been more than a dozen of them, in which the rectal bag was used, the peritoneum did not appear in the wound. If the peritoneum is not pushed up three inches, it is certainly pushed up some. And with this precaution the peritoneum has not appeared in the wound where the rectal bag was properly distended and the bladder was distended afterward. Upon the dead subject I have done this operation over one hundred times, and occasionally the peritoneum would be encountered. In a few instances it dropped down quite upon the pubis; but in these cases it was not pushed up either by distension of the bladder or distension of the rectum.

Of course in my remarks I simply refer to my experience, and my observation is corroborative of the wisdom of taking all means to prevent any possible wounding of the peritoneum, which is almost certainly a fatal accident unless the peritoneum be promptly closed up without any chance of infection. I look upon the operation, proper care being taken, as one comparatively easy to do. I look upon it as even less attended by risk than the operation which Dr. Palmer prefers, so far as the operation itself is concerned.

With respect to the hemorrhage which occurs after this operation, so far as the simple operation is concerned, I agree with Dr. Roberts that it is rarely troublesome. In operations upon the bladder for the removal of tumors, and especially in prostatic troubles, the danger of hemorrhage is very considerable, and it has been the practice of some to cauterize the bladder with the hot iron or thermo-cautery. A safer step is to tampon the bladder with gauze fixed by a thread drawn out through a perineal wound or through the urethra as

suggested by Keyes. There are a number of points with respect to the management of this operation presented in the paper that meet my approval thoroughly. It should be the object of every surgeon to avoid injury to the peritoneum in operations of this character, and I believe we ought to employ every possible means in order to prevent injury. The details of the technique which Dr. Chenoweth has given us are both interesting and adequate; are much upon the original modifications by Petersen and, having stood the test of time, are to be relied on.

DR. W. C. DUGAN: I am a little surprised at the position taken by Dr. Grant in reference to my former remarks. I did not mean to criticise Dr. Hunter McGuire, except in as far as his statement that "supra-pubic cystotomy is as simple as opening a boil." I agree with Dr. Palmer that it was an operation of considerable magnitude. Now the point I wished to make was, the best means of avoiding the dangers in this operation were by taking the precautions which I have mentioned, i. e., not to distend the bladder until you expose the prevesical fat, and then in order to locate the peritoneum after the bladder is exposed. If you will follow the precaution now being practiced by the best surgeons in America and Europe, there will be no danger of wounding the peritoneum; that is, to first distend the bladder, then slip your fingers well down toward the neck, lifting the bladder up into the palm of your hand until you feel the fold of the peritoneum slip above, then the bladder can be incised without danger.

One other point: I am greatly surprised to hear Dr. Grant state that he can lift the peritoneum three inches by an eight ounce rectal bag. I think experiments have proven pretty clearly that the bladder can be distended with water and afterward distend the rectum and it simply forces the prostate forward but does not perceptibly increase the space between the fold of the peritoneum and the symphysis.

DR. A. M. CARTLEDGE: It has been my observation that whenever a new operation comes up in surgery everybody is writing upon its technique, etc. After a while it dies down, and all the time it is being subjected to the crucial tests of experience and practice. After a year or two you will find some of the most interesting points concerning it have never been

brought up. I think this is notably the case with supra-pubic cystotomy. It was largely written upon a year or two ago, but I have hardly seen it mentioned within the last eighteen months. I perfectly agree with almost everything Dr. Chenoweth has said in reference to the operation. I have myself paid considerable attention to the matter, have done several operations, and witnessed others. I do not quite agree with the essayist with reference to the use of the rectal bag. I believe, like Dr. Dugan, that the rectal bag cannot raise the peritoneal fold proper more than one-quarter of an inch. If this were the case there would be danger of rupture. I have never used the bag as I never considered it of any service. Further, the rectum is the seat of a plentiful nerve distribution. I think it was proven several years ago that often very alarming syncope resulted from simple distension of the rectum by the speculum, and I see no reason why anything that would distend the rectum might not produce the same result. I think it would probably be the most dangerous part of the operation to tightly distend the rectum, even with a soft rubber bag.

I believe that a free incision should be made over the bladder, the prevesical fat and peritoneum can be peeled up from the bladder with the fingers until everything is out of the way, then the necessary incision can be made in the bladder for removing any growth or stone that may be found. I think the supra-pubic operation preferable to the perineal method for impermeable stricture; in fact, in my opinion the perineal operation without a guide is a most dangerous procedure, and useful only as a life-saving measure in the cases of enlarged prostate of the old.

DR. JAS. S. CHENOWETH: I use Petersen's bag in these operations because I believe better results can be obtained with it than with any other. I recommend the use of the rectal bag to raise the peritoneum, but more especially to raise and steady the base of the bladder which greatly facilitates operation on this organ.

I am sorry there was no more discussion upon the question of drainage, and whether the bladder should be fastened to the abdominal wall or dropped back into the pelvis. In most of the operations I have seen, the custom has been to simply open the bladder, remove the stone or

growth, and then allow the viscus to drop back into the cavity of the pelvis. This necessitates the use of a tube for drainage, which is liable to leave a small discharging sinus after the operation; especially is this the case when the operation is done for cystitis from enlarged prostate, where the obstruction at the bladder neck cannot be thoroughly removed.

#### Preventive and Curative Drinks and Medicines.

Put not your trust in nostrums; cholera does not "come by Providence and go by medicine," although that is a common and ignorant belief in respect to it, and many other diseases. A tried and safe preventive of the tendency to diarrhoea (which should always be checked) is sulphuric acid lemonade, made by acidulating boiled and sweetened water to taste with dilute sulphuric acid (or, as at the post-office, Dr. Waller Lewis's very palatable sulphuric orangeade.) The citric acid lemonade lately vaunted was rather inferior in value to this. The cholera bacillus, as we now know, was favored by an alkaline fluid, and did not live in acid media. An excellent and well tried preventive of the prevalent slight diarrhoea was the Vienna mixture (used in barrels formerly in hospital practice.) It consisted essentially of fifteen drops of dilute sulphuric acid to six ounces of boiled and sweetened water, to which might be added, under medical advice, ten drops of sulphuric ether and five drops of laudanum for an adult. On ice-bags, camphor solutions, and other expedients of the kind no reliance could be placed, except in skilled hands and for selected cases. Many people poisoned themselves with camphor during a late epidemic, as a precaution against cholera. Once established, and in well-marked cases of Asiatic cholera, drugs would do little to cure. The mortality of cholera all over the world and in all epidemics had defied drugs—just as severe arsenical poisoning would do—and varied according to intensity and the age and condition of the patient from forty-five to sixty-four per cent. It was eminently a case in which prevention was far more efficacious than cure.—*Ernest Hart.*

Manager. "What's the row?"

Assistant. "The two-headed boy is quarrelling over a piece of pie."



## CORRESPONDENCE.

## NEW YORK LETTER.\*

At a recent meeting of the Practitioners Society of New York, held at the Academy of Medicine, a discussion took place between the prominent physicians present on the question of food in continued fevers. The question was of importance as it is the general belief among the profession that solid food should not be given, particularly in typhoid fever.

Dr. A. H. Smith said that he believed he had often prolonged cases of typhoid by restricting his patient to a milk diet, and that he had often noticed a decided improvement as soon as solid foods were given. He thought that fermenting and irritating drinks, so frequently given, had a more deleterious effect upon the ulcerated patches than had solid food; that solids were not in a condition upon reaching the ileum to irritate a typhoid ulcer, and that milk dilutes digestive fluids and renders them inferior as solvents.

Dr. J. W. Roosevelt said that a prolonged milk diet prolonged a fever. He mentioned cases in which the cessation of a milk diet, and the giving of stale bread and finely chopped meat, gave marked good results; a patient on a fluid diet is hungry, and hunger is pain; the giving of solids, and consequent relief of this pain, lowers the temperature which is kept up by the pain. Professor Beverly Robinson brought up the point that milk curdles in the stomach, hence part of it becomes solid; and this solid is more apt to irritate typhoid ulcers than would such foods as bouillon, beaten egg, and wine jelly, as they are not solid upon reaching the ulcers.

Dr. Robert Abbe feeds his typhoid patients peptonized milk, junket, scraped meat, baked potatoes and stale bread. He said that none of these were any more solid upon reaching the seat of the ulcers than would be milk.

Dr. W. H. Polk said that a few years ago it was the custom to keep laparotomy patients upon an exclusive milk diet for two days before and for ten days after the operation, and that many fatal cases, at-

tributed to sepsis and shock, were due to inaction. He has noticed a decided falling off in the death-rate since this custom has been abandoned.

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At a recent clinical lecture in Bellevue Hospital, Professor H. M. Biggs strongly contradicted the teachings of most pathologists regarding the etiology of diabetes mellitus. He said that the malady was in no way due to any diseased condition of the liver; that a pathological liver may cause glycosuria, but that this was in no way related to diabetes mellitus. He gave as its cause a brain lesion from traumatism, or mental anxiety, grief, sudden fright, or mental shock of any kind. He said that heredity was a prominent predisposing cause, and that he has often noticed several cases among members of the same family.

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Professor W. T. Lusk performed symphysiotomy on a patient at the Emergency Hospital a few days ago. The woman had been in labor thirty hours when brought to the hospital. An attempt had been made by an outside physician to deliver the child with forceps, which resulted in severe lacerations of the vagina and cervix. The degree of pelvic contraction was such as to forbid any attempt to deliver the child without the operation. As the condition of the mother would not permit of the severe mutilation necessitated by Cæsarian section, the choice lay between craniotomy and symphysiotomy. The latter was chosen as it presented the advantage of the delivery of a living child and involved the mother in less risk from sepsis. After the pubes were shaved and rendered aseptic, an incision was made through the mons veneris and the symphysis divided from below upward. Assistants held the sides of the pelvis, not allowing a separation of the pubic bones of more than an inch, thus avoiding damage of the sacro-iliac synchondrosis and the pelvic viscera. The child was then delivered by the forceps. The pubes were brought together and held in place by sutures through the soft parts and a tight bandage

\* Special Correspondent to THE MEDICAL AND SURGICAL REPORTER.

around the pelvis. At the present writing the child is doing well and the mother is living. But the length of time she was in labor, the severe lacerations she received before admission and her critical condition when an operation was decided upon, give her but slight chance for recovery.

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Dr. L. A. Sayre, in a recent lecture, stated that he had exsected seventy-three hip joints. The operation is done much less frequently than a few years ago, as modern physicians are able to diagnose and properly treat hip-joint disease in its incipient stage. The venerable professor exhibited at the lecture a dozen patients on whom he had performed the operation. Most of them walked without any inconvenience and without the use of a cane or crutch; call were able to run up and down stairs and to do their work as well as any. A patient on whom he operated several years ago and removed the head of the femur and upper three inches of the shaft, recently won a prize in a skating contest held in Central Park. He said that the good results were due to the care he exercised in the preservation of the periosteum from which new bone developed and replaced the removed tissue.

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Although the present epidemic of typhus fever is on the decline, new cases and deaths are reported every day. At present there are about thirty-five infected buildings in the city, many of which are cheap lodging houses. Cases when discovered are at once transferred to Bellevue Hospital, where they are kept out-of-doors in carefully constructed and well heated tents until their removal to North Brothers Island. The tent plan not only lessens the liability of the extension of the infection to the hospital patients, but is a sanitary measure proven to yield good results in any specific fever. There is no danger of the patient catching cold if he is not subjected to a draught; his temperature is lowered, and the poison is diluted as it cannot be in a hospital-ward or sick-room. The treatment has been to reduce the temperature, relieve restlessness, make the patient comfortable and promote nutrition. The death-rate has been about twenty-five per cent.

Cantani claims that no other agent equals tannic acid in the treatment of cholera.

#### Treatment of Compound Fracture.

A writer in the *Boston Medical and Surgical Journal* says that the treatment of compound fractures, during the past few years, has undergone radical changes and marked improvement, which has been brought about by two causes: (1) Thorough exploration and cleansing of the wound and antisepsis. (2) By the recognition of the importance of the physiological principle of complete rest to a fractured bone. The results from older methods in Guy's Hospital in the twenty years from 1841 to 1861, was a mortality of 28 per cent.; in the New York Hospital during a similar period there was a mortality of 48 per cent.; in the Obuchow Hospital Report of St. Petersburg there was a mortality of 68 per cent. Under modern methods Dennis reports 681 cases of compound fracture with one death from sepsis, giving a death rate of one-seventh of one per cent. The important points to be observed are: (1) That every compound fracture of the thigh, leg, arm or forearm, should be rendered scrupulously surgically clean and should be absolutely immobilized. (2) That this immobilization is conveniently obtained by the light, circular plaster of Paris washed bandage. (3) That a plaster of Paris bandage should be allowed to remain on a limb over a fortnight in the first month of treatment of a compound fracture, as backward bowing and lateral displacement can be avoided by this precaution. (4) That while pus, slough, necrosis or deformity may exceptionally occur, yet the rule is, union by first intention, and the early restoration of limbs to usefulness.

#### Treatment of Ringworm.

Crawford Warren, F. R. C. S. I., in the *London Lancet*, suggests the following treatment for this troublesome affection:

The affected region should first be washed with soap and warm water containing a little carbonate of soda and then well dried. Acetic acid should then be thoroughly applied with a small brush, and in the lapse of about five minutes, when the acid will have soaked into the part, an ointment composed of sixty grains of chrysophanic acid to an ounce of lanoline should be rubbed in. This treatment should be carried out daily for such a period as may be necessary.—*Prac. Mon.*

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SATURDAY, JANUARY 29TH, 1893.

## EDITORIAL.

### ABDOMINAL SURGERY—ITS REVOLUTION.

In the *Indiana Medical Journal* for December there appeared an article by an eminent western surgeon entitled "Abdominal Surgery—Its Evolution and Involution."

This article is remarkable more for what it insinuates than for what it says. While it is strong in many respects and offers plenty of food for thought, its animus seems to be a desire to smirch the private character of Lawson Tait and to belittle his work. It is an effort to create the impression that he and men who like him publish a low mortality in their abdominal work are, if not downright liars, at least remarkable for handling the truth with a great deal of economy.

Mr Tait's work and character have so long been open to the inspection and scrutiny of the whole medical world, his reports have been so often verified, and his results duplicated by his pupils and others in this country that any attempt at the hands of an American operator to belittle him is likely to create suspicion that somebody has a grievance.

When an operator demands that hereafter all who publish low mortalities shall be compelled to furnish affidavits and certificates that their statistics are true, it begins to look as though he might be measuring others by standards applicable to himself. Such a method of reasoning is a very fallacious one indeed. The fact that those men who publish results in abdominal work with a mortality as low as three per cent. invite the closest inspection of their work and have their operating rooms daily crowded with visiting physicians from all parts of the country, is a complete refutation of any insinuation that tin-horn blowing constitutes the chief element in their success and that falsehood predominates in what they publish. There are too many honest, earnest and closely scrutinizing physicians visiting and studying these men, who write up what they see, and that only from a laudable desire to spread the truth for the benefit of others who seek information; and who expect their patients to profit by what they gain in knowledge—there are too many jealous



observers for accusations like those which permeate the article under consideration, to prove other than boomerangs to the accuser.

If the surgeon who wrote this article will spend a little more of his next vacation in Philadelphia and less in Vienna, he can have an opportunity to see just such work as that described by a number of men whom he dubs sycophants. Then, if he be the well-spring of truth his article would lead us to infer he claims to be, he can go home, and if he publishes anything of what he sees, it will be couched in a far different spirit than that revealed by the evolution and involution of his late effort. He will at least be enabled to recognize the truth when it confronts him in the King's Highway.

It was Lawson Tait who revolutionized

the surgery of the abdomen, and who taught us that it was not the *going into* the peritoneal cavity that produced disaster so much as the *manner* in which it was done and *what one took in with him*. His saying that he would as soon put his finger into the peritoneal cavity as into his pocket was no idle boast, but came from an honest conviction born of an experience in more than three thousand sections.

Whenever another man has added to modern surgery as many things as Tait, and has taught the surgical world as much; whenever one arises to whom suffering woman owes so much; then, and not till then, may he brand Tait a liar, if he be willing to confess ignorance as extensive and principle as unstable as the three thousand miles of water between him and the traduced.

#### "HOUSE" QUARANTINE.

Last week we noted the passage by the United States Senate of a National quarantine measure, which poor as it was, seemed to offer some hope of protection against foreign invasion by armies of cholera microbes. This measure, crippled as it was by passing through the mill of practical politics, was sent to the House. Whence, after the skillful and patriotic treatment at the hands of Tammany scientists in consultation with experts from Florida, Louisiana and Texas, it emerges totally emasculated. The bill as sent from the Senate was amended in the House to prevent it in any way restricting, relaxing, modifying or suspending State or municipal quarantine regulations. The elimination of this objectionable feature was accomplished by citizen Bourke Cochran, of Tammany (formerly called New York State), who discovered in it the thinly disguised intention to make the Federal authority superior to that possessed by the appointee of his liege mas-

ter, His Majesty, the Dictator of Tammany Hall.

As suggested by a Representative from another State, the title should be amended so as to read "A bill authorizing the States to declare quarantine against the United States." This measure should become a law immediately, so as to permit the Burgess of any little town on the sea coast, or on a State line, to defy Federal regulations, and enforce its own effective municipal laws.

It is curious to note how the same object appears viewed from opposite sides. The legend tells us of the two knights who engaged in mortal combat over the composition of the shield, of which each had seen only one side. In this part of the country there is a growing belief that the opposition to a Federal Quarantine was largely aided and abetted by an alleged steamship and railroad combination, whose interests it would seem to have antagonized. From the point of view

of a Texas medical contemporary of undoubted honesty and ability, the bill appears to be *supported* by this same alleged lobby of steamship and railroad companies in their own interests. Thus it is that whether in support of, or opposed to this measure, the steamship and railroad companies are very considerable factors in the question. This bill will now go back to the Senate, and if it is received as an original House bill (and it surely is

original enough), it may be amended sufficiently to make its meaning diametrically different, and then be considered by a conference committee. The results of this last combination will be awaited with curiosity by the Profession which, in event of an epidemic, will bear the heaviest portion of the wearisome burden, and will be made the popular scape goat for the sins of omission and commission of the Representatives of the people.

## TRANSLATIONS.

### RUPTURE OF THE UTERUS.\*

H. Fehling, (*Klin. Vortr. N. F.*, No. 54.)

The author presents the history of a case as the foundation of his dissertation on this subject.

The case a II—para of thirty-six years, having a contracted pelvis (*Conjugata vera 7.5-7.7*). The first child had been small and was born spontaneously. The author saw the patient first during her second labor after a spontaneous rupture of the uterus had taken place in the anterior and lower portion of the uterine wall. Delivery was at once performed by perforation and dilatation, and the treatment consisted of passing a tampon of iodoform gauze through the vagina into the uterine opening. The size of the tear, its possible septic condition due to the blood and meconium, the persistent hemorrhage all induced the author to resort to abdominal section in order to unite the tears in the uterus. Careful investigation disclosed a second tear in the uterus; both were closed by several rows of sutures; drainage and recovery. In connection with this case F. considers the causes of uterine rupture, its symptoms and treatment.

In threatening rupture of the uterus he advises the use of chloroform and morphia as a means to reduce the too active contractions of the uterus and if possible to terminate labor by forceps or perforation. In transverse positions the obstetrician will find it necessary to first attempt,

under complete anesthesia, careful version. If tetanic contractions of the uterus remain unabated, decapitation is indicated. If the rupture has taken place, prompt and careful delivery is indicated in which perforation or cephalothrypsia may become necessary. It is rarely possible to extract the fetus by its feet through the tear. Version is in all cases of existing rupture contra-indicated. If the child has escaped entire or partially through the tear into the abdominal cavity, the only proper procedure is laparotomy in order to deliver the child and at the same time repair the injuries to the uterus. If the tears are extensive or if they should be circular, partially separating the uterus from the cervix, Porro's operation is indicated.

The question which is presented at the present time, namely, should laparotomy be the first step in the treatment of rupture of the uterus, even though the child has been extracted per vias naturales, is answered by the author in the affirmative, provided the condition of the patient will permit so grave a procedure.

If section is decided upon, the author's mode of procedure is as follows: After opening the abdominal cavity, it is first cleansed of the blood and amniotic fluid, etc., by means of the physiological solution of salt. The uterus is then raised, the wound disinfected, and an iodoformized strip of gauze passed through the wound and allowed to extend out through the vagina. The wound is now closed with three rows of sutures, respectively uniting

\* Translated for THE MEDICAL AND SURGICAL REPORTER, by Marie B. Werner, M. D.

the decidual, muscular, and serous layers; if necessary, some superficial stitches are added; after again cleansing the abdominal cavity thoroughly the abdominal wound is closed. The iodoform gauze is removed from the vagina after twenty-four hours.

In cases where incomplete rupture has taken place, where the peritoneal covering is intact the iodoform gauze tampon into the uterus is advocated by the author, a procedure which the author preferred to the

use of a rubber drain. The gauze in these cases is not removed until from the sixth to the tenth day.

Formerly more than three-fourths of the patients died as a result from this injury.

F. believes that careful suturing of the uterine wound will improve the prognosis in these cases, the same as that of Cæsaræan section, since Sænger's method of suturing of the uterus has become recognized and practical.

#### CONTRIBUTIONS TO THE PATHOLOGY AND SURGICAL THERAPY OF CHRONIC DISEASES OF THE CÆCUM.\*

F. Salzer (*Archiv. of Klinische Chirurg.*, XLIII page 101). The material used in this study has been taken from Billroth's clinic and covers a space of ten years. During this time there were twenty-five operations on twenty-three patients for chronic inflammations of the cæcum. A fistula resulting in one of the cases necessitated a second operation. The other case was a resection of the intestine for carcinoma. A return of this disease made it necessary to perform Ileocolostomy.

Among the twenty-three patients, fifteen were males and eight females.

Ten were resections for carcinoma (eight males and two females). There were four recoveries (two males, and two females). Five operations were for tuberculous ulcerations and stenoses of the intestines at the cæcum—(five males, one female). Of these there were four recoveries (three males, one female). Eight operations for fecal fistula (three males, five females). Of the five females, three recovered. Two males recovered from the operation, one of which however required a second operation owing to the presence of a fecal fistula. The third male required a resection of the colon which ended fatally. The mortality of non-malignant tumors was twenty per cent. That of malignant tumors sixty per cent. That of fecal fistula 57.5 per cent. The mortality was higher among men (50 per cent.) because they were seen too late, while that of the women was 22.2 per cent. Alarming intestinal symptoms existed in three cases at the time of operation. The difficulty in

diagnosing between tubercular and carcinomatous growths in the appendix is very great, the microscopical investigations being the only reliable means. Of the operations there were four intestinal sutures including one lateral suture; eighteen intestinal resections, and three intestinal anastomoses. In regard to the resection of the intestines the author believes that the simple transverse section of intestines with a circular suture can be recommended also for the resection of the cæcum, with this exception, that owing to the difference in the lumen of the cut ends of the intestines at this location one would have to be cut a little diagonally. If the tumor has become fixed by the fistulae and perityphlitic abscesses the mode of operating as well as the prognosis becomes changed. Of the whole of the eight fecal fistulae only one was thoroughly cured, four returned and three died, while of the seventeen other cases ten were cured and seven died. The author does not approve of intraperitoneal tampons or drainage.

Traveler.—“Do you think the lynch law you have here decreases the number of murders?”

Native.—“Wall, I dunno; but it decreases the number of murderers.”

“If you don't stop smoking in office hours, you'll get fired, that's all,” said Wagg to his bookkeeper.

“Is that quite just to one who does his work faithfully?” asked the scribe.

“Certainly. Where there is so much smoke, there must be fire.”

\* Translated for THE MEDICAL AND SURGICAL REPORTER, by Marie B. Werner, M. D.



### Ischio-Pubeotomy, or the Operation of Farabeuf.\*

This new obstetric operation is described by Pinard in a communication to the Academy of Medicine of Paris. He employed it in the case of a woman thirty-two years of age, who presented herself to him with an oblique pelvis associated with an ankylosis of the left sacro-iliac articulation. Her first pregnancy had been terminated by means of basiotripsy; the second by premature labor at the eighth month; the third was an instrumental labor resulting in the death of the fetus, and almost that of the mother; the fourth was terminated by premature delivery of a dead child; and finally she came in November, 1892, again pregnant and expressing the wish to be delivered of a living child. At first it was decided to perform symphyseotomy, but the existence of the sacro-iliac ankylosis led to the belief that the gain following the operation would probably be insufficient, and it would be impossible by it to sensibly increase the dimensions of the antero-posterior diameter, which was reduced to eight centimeters and a-half. Cæsarean section appearing to offer but slight chances for the mother's recovery, the operation of ischio-pubeotomy was decided upon. According to Farabeuf, the originator of the method, this operation will permit of the passage of a head much larger than the normal, nearly a sixth larger. The technique was as follows: Labor having lasted fourteen hours the ichio-pubic ramus was divided and then the horizontal branch of the pubis on the ankylosed side five centimeters from the median line. The Tarnier forceps were then applied at the superior strait and with scarcely any traction a living infant weighing 3,970 grammes was delivered. During the traction upon the forceps there was a spontaneous separation of the two severed segments of 2.6 centimeters, and, at a given moment, of four centimeters.

The sole difficulty of the operation consists in passing the chain-saw with which to cut the horizontal branch of the pubis. With a suitable needle this difficulty disappears. Hemorrhage is almost nothing. After delivery the bony fragments come in contact and sutures for this purpose

are unnecessary; the soft parts must be sutured. The after treatment is very simple.—*Le Bulletin Médical*, Jan. 11, 1892.

### Fatal Suppuration Beneath the Shoulder-Blade.\*

F. A. Treskin, (*Med. Rundschau*, 1890) Suppuration beneath the shoulder-blade is of rare occurrence, indeed, so rare that the author after searching numberless text books in the German and French Literature, was unable to find any mention made of it, except a slight allusion to it in Hyetl's Anatomy.

The case which he reports was as follows:—The patient, a marine, was admitted the 29th of July, into the Lazaretto, with symptoms of acute fever, sensations of heat and cold, headache, etc. There was present diarrhoea and the thermometer registered 38.8, and in the evening, rose to 39.5. The following day acute pains appeared in the right arm, the patient coughed, the axillary glands were swollen and painful and there was some bronchial breathing. On the fourth day the entire right side, beginning from the median line in the back was swollen. At the point where the swelling was most reddened an exploratory incision was made down as far as the ribs. There was no pus present, only a slight discharge of bloody serum. Fluctuation could not be demonstrated. Anthrax was thought of, yet the microscopical examination did not corroborate it. The temperature now became sub-febrile, the pulse became slower until the fifteenth day when the patient died.

In closing Treskin lays stress upon the difficulty of the diagnosis and presents the illness as one of great gravity, particularly when the abscess lies in the deeper structures.

Little Bessie had been taken in to see her new brother for the first time. "Do you think you will like him, Bessie?" asked her father.

"Why, yes," she said, clapping her hands delightedly. "There isn't any sawdust about him at all, is there? He's a real meat baby."

\*Translated for THE MEDICAL AND SURGICAL REPORTER, by W. A. N. Dorland, M. D.

\*Translated for THE MEDICAL AND SURGICAL REPORTER, by Marie B. Werner, M. D.

## ABSTRACTS.

## RELATION OF RHEUMATISM AND CHOREA.

Dr. Townsend (*Archives of Pediatrics*) in discussing this subject before the *American Pediatric Society*, says:— "Whatever the exact relations of chorea and rheumatism may be, it seems to me that a study of cases like these teach us the very practical lesson that in a choreic child we should be wide-awake to any indefinite pain as evidence of rheumatism, and should treat it accordingly, and that we should be particularly watchful for endocarditis."

As a summary he offers the following deductions.

1st. Fright, eye-strain, debility, and school-pressure, particularly the latter, which often include some of the former, are potent exciting causes of chorea.

2nd. Rheumatism, although absent from the history of at least half of the choreic patients, occurs with greater frequency among the choreic than the non-choreic cases.

3rd. There is an intimate relation between chorea and rheumatism.

4th. The heart murmur so frequently found in chorea, sometimes associated with chorea and sometimes not, is in a considerable proportion of the cases due to endocarditis, and leads to organic valvular disease.

Dr. Crandall is of the opinion that the relation between rheumatism and chorea is a very close one and the question arises whether there is any chorea without rheumatism. Is there such a disease as fright chorea or hysterical chorea? I believe that there is, in the same sense that there is a rheumatic chorea. A study of the disease leads strongly to the belief that there is some underlying predisposing cause aside from rheumatism, fright, or hysteria. A dozen children have rheumatism and no chorea. The thirteenth has a mild attack of rheumatism and develops a severe chorea. The children in certain families are almost certain to have chorea if they contract rheumatism. Ten children are frightened by a dog and never have chorea; the eleventh at once develops a nervous disorder which increases in severity for two weeks and lasts for six months. A hundred children are scolded by their

mothers with no perceptible results of any kind. One of my patients was scolded by a mother who had herself had chorea and at once developed an attack. That there is some predisposing neurotic element underlying all this I thoroughly believe. What it is I do not know. Not every one exposed to the bacillus of tuberculosis acquires the disease. That indefinite factor we call predisposition is lacking. Not every child suffering from rheumatism or subjected to fright has chorea. He is not predisposed to it. I should class rheumatism, fright, hysteria, excitement, pregnancy, not as all-powerful agents for the production of this disorder but rather as exciting agents for the production of a disease in subjects predisposed to it, the most universal and potent of which is rheumatism.

Dr. Adams in discussing this question presents the history of fifty cases of chorea treated at the Children's Hospital in Washington from which he draws the following conclusions.

1. That chorea is due to rheumatism in but a small percentage.

2. That the heart murmurs are hæmic in the largest number of cases.

3. That the successful treatment would seem to exclude latent or apparent rheumatism.

4. That anæmia and chlorosis are well marked in nearly all cases.

5. That nerve impoverishment is by far the most potent factor.

Dr. William Osler, in closing, says, it seems quite impossible to bring all the cases of chorea into the category of rheumatism. Our German colleagues, as you know, have not found more than sometimes ten per cent., sometimes fifteen per cent. In the large number of cases which I have analyzed, and the great proportion of them I have gone over myself with especial care with reference to the history of growing pains, in 554 cases there were only fifteen per cent. with a positive history of articular trouble. Including those with pains of any kind whatever the percentage was only twenty which comes to about the percentage given by Dr. Townsend. Unless we largely expand our con-

ception of rheumatism in children the cases which have come under my observation in Philadelphia and Baltimore, certainly the large proportion of them, there is no definite history of rheumatism, and the absence of the subcutaneous fibroid nodules which our English colleagues lay such stress upon is particularly striking. The only instances I have seen in this country have been in adults, not in children.

The only other point I would refer to is as to the really remarkable frequency of organic heart disease in the subjects of chorea. In the 110 cases from the *Infirmary of Nervous Diseases* in Philadelphia every one of which had had chorea two years prior to the examination, there were 54 with signs of organic heart disease existing. I do not mean 54 with heart murmurs. There are plenty of people with heart murmurs who have not

heart disease, but signs of enlargement of the heart and murmurs of such a character as go only with organic valvular disease; and in more than fifty per cent. of these cases there has been no history of rheumatism.

A point referred to by Dr. Townsend is the extreme frequency of endocarditis in chorea. There is no other disease with which endocarditis is known to be so frequently associated, no other disease the post-mortem records of which show such a large proportion of endocarditis. The nature of the disease and its relationship are still doubtful, but the points which have been brought out here are of considerable interest and show I must say a larger percentage of rheumatic cases than has yet been shown in any series in this country, approaching much more to the English than to the German percentage.

#### HYDROCEPHALUS.

Dr. A. Jacobi in speaking of Hydrocephalus (*Archives of Pediatrics*) states that in the normal baby's head, while the fontanelles are open, you can count the pulse there better than at the radial; you can see the pulsations. But as soon as hydrocephalic effusion takes place to any extent, this pulsation of the fontanelle ceases.

In most cases, hydrocephalus, is either congenital or acquired early. When it is congenital, the brain is never fully developed, while the skull may be too large, or normal, or too small, at birth. Such a case may be the result of an embryonal inflammation, though no positive evidence of it can be found. The *ependyma* is often found thickened. The serum contains but little albumen, about one-tenth of a part per mille. Many such cases have been attributed to the obstruction of the *aquæductus sylvii*, or to that of the *foramen magendie*; in others they have been found normal. Inebriety and syphilis of the parents have been charged with producing congenital hydrocephalus. It is often found in numbers in the same family.

Acquired hydrocephalus is inflammatory in most cases; that appears to be proven by the condition of the serum

which—very much like that of transudation and exudation—contains one per mille and much more of albumen. It is the result of interrupted circulation, for instance by the obstruction of the *venar magna Galeni* or the *sinus recti*, brought about by exudation or by tumors, or by slow circulation through chronic hyperæmia depending on general *rhachitis*. In a number of cases it has depended upon the presence of a tumor which has compressed a large vein, thereby giving rise to an effusion of water. In many cases, however, it is an inflammatory product, and the earlier it occurs, say during fetal development, the more detrimental are its effects. The immature, soft, and flabby brain is compressed and injured or destroyed. I have seen a whole hemisphere wanting, the meninges being filled with absolutely nothing but water. In a number of cases the lateral ventricles are filled to such an extent that while the head is very large, the brain is atrophied, and sometimes nothing is left but a thin layer of cerebral tissue. These are the worst cases; as I said, the sooner the process begins the worse they are.

When it comes to treatment, you can do much more for those that are acquired than you can for those which commenced in fetal



life. When the commencement was in early foetal life there is very little brain tissue, and almost every one of such cases will slowly die. Acquired cases may be benefited, particularly when they go with rhachitis. Tincture of iodine, iodoform ointment and vesicatories have been applied over the cranium, all to no purpose; the iodide of potassium has been given without benefit, for where there is no brain there can be little response, new ef-

fusion will take place all the while, and the result of treatment is very insignificant. The same must be said of vesicatories, purgatives, and diuretics. It has been proposed to tap the brain. A number of recoveries have been reported from this practice. I cannot say that I have ever succeeded in curing one by this method, with or without the injection of iodine, which has also been proposed and practiced.

#### VAGINAL HYSTERECTOMY FOR CANCER WITH REPORT OF FOUR CASES.

Dr. Noble remarks that as the operation of hysterectomy is not conceded by the profession in general, to be the logical means of eradicating cancer of the uterus, too much stress cannot be laid upon the importance of reporting all cases operated upon, and the final results—whether cure or recurrence. And the *value* of the operation, should be determined by the work of the *few skilled* surgeons—who have reduced their mortality to five per cent.—rather than by the results obtained by a *great number* of surgeons, many of whom are inferior operators, if not absolutely bad ones. Vaginal hysterectomy being such a comparatively new operation, sufficient time has not elapsed to place on record the remote results of any large number of cases. The statistics of certain German clinics attest a permanent cure in about forty per cent. of cases. As the laity and many also of the profession are proverbially hard to convince as to the efficacy of new operative measures—particularly when asserting the probably permanent cure of the much-dreaded cancer—it is of the utmost importance that all surgeons report all cases under their charge, and make additional reports from year to year, until it can be definitely shown that cancer of the uterus is curable. The theory of climacteric hemorrhage is, most unfortunately, still believed in by a large majority of the public, and many professionals as well. By experienced surgeons and gynecologists such hemorrhage is now acknowledged to be entirely abnormal and indicative of some gross disease of the

uterus,—cancer, fibroid tumor, or hyperplastic endometritis.

Were this fact generally recognized, the first great step toward the cure of cancer of the womb would be taken, as it could be diagnosed and removed in its earliest stage,—making a cure almost certain. The following is the report of four cases operated upon by Dr. Noble—they being the only ones out of seventy-five cases which were not too far advanced for operation. Of these four cases, three of the women were multiparæ, and the other had had a single premature labor. The common history was purulent and profuse leucorrhœa, with more or less pelvic pain. The first case having small epithelioma of the cervix, was operated upon in May, 1889, cervix being amputated. In November of the same year, as the growth continued, vaginal hysterectomy was performed, allowing the ovaries to remain. Up to January 2nd, 1893 she was in robust health, and showed no symptoms of a recurrence of the disease. The second case was malignant adenoma; operation, removing uterus and ovaries, took place January 5th, 1892, and up to the present the patient's condition is satisfactory. Number three was also a case of epithelioma of the cervix. The uterus and ovaries were removed October 5th, 1892, and the present condition of patient satisfactory, although she experiences some pain caused by an exudate about the left ovarian stump. Case number four,—epithelioma of cervix—operation December 21st, 1892. The left ovary was converted into a cystoma which was ruptured in the removal; peritonitis immediately followed and death occurred on the fifth day.

\* Read at a meeting of Phila. Obstet. Soc., Jan. 5th, 1893.

Dr. Carl Koller (*New York Med. Jour.*) in speaking of "The Subconjunctival Application of Cocaine in Eye Operations," states that his suggestions, made some eight years ago, as to the use of instillations of cocaine solutions to produce anæsthesia for operations on the eyeball met with general approbation, and subsequently the usefulness of cocaine in other branches of surgery was explored by other investigators. He states in part:—"Right in my first experiments with animals, and later in eye operations, I noticed the fact that by instillations of cocaine we were sure to achieve an anæsthesia of the superficial tissues only. I could scratch, or burn, or cauterize the cornea without the slightest pain, but the moment the iris prolapsed or was touched with an instrument, animals and human beings gave brisk signs of pain. In a great number of cases I succeeded in making the iris anæsthetic by beginning the instillations half an hour before the operation, but I did not succeed every time. In my visits to eye clinics of different countries I found that only in a very few of them were instillations begun a sufficient time before the operation to achieve this end. This circumstance, in my opinion, detracts from the value of cocaine anæsthesia in a great number of eye operations. The patient does not care which tissue hurts him. He says he has pain, and calls cocaine anæsthesia a beautiful but delusive dream. The pain on touching the iris is especially troublesome in cataract extractions. The patient, who has been promised a painless operation and did not experience any pain in cutting the cornea, is suddenly thrown out of his illusions of a painless operation, makes sometimes a sudden jerk, and may thus endanger the success of the operation."

In squint operations one can notice every time that the patient does not feel the conjunctival cut, but does react quickly when the tendon is seized with the hook or forceps and divided.

Very soon after my first communication I began using subconjunctival injections in squint operations.

I proceed in the following way: After having rendered the conjunctiva anæsthetic by the instillation of a four per cent. solution, I insert the speculum and, by means of a mouse-toothed forceps, seize a fold of the conjunctiva over the tendon to be

operated upon. The needle of a hypodermic syringe is inserted through this fold into the subconjunctival tissue as deep as possible, and a few drops of a two-per-cent. solution of cocaine are injected. For injections I use a two per cent. solution in preference to a four or five per cent. solution. I consider 0.05 (two thirds of a grain) as the utmost limit for adults that can safely be applied as an injection if the locality of injection is on the head, while on the limbs double the amount may be allowed. But I am careful to keep a good part within this limit. With a solution of two per cent., and even of one per cent., an entirely satisfactory anæsthesia can be produced if the solution is well distributed over the field of operation, and I attribute it to this use of weak solutions that I have not encountered yet any alarming accidents from the use of cocaine.

After the injection the speculum is removed from the eye and the eye is closed, so that the artificial oedema of the conjunctiva is given time to disappear, which it does in about five minutes. The disappearance may be helped by a little rubbing. If you have prepared a patient in this way, you can perform the operation without the slightest pain—whether it be tenotomy or advancement."

#### Peroxide of Hydrogen.

CHAS. MARCHAND REFUTES THE STATEMENT OF  
PROF. A. JACOBI.

My attention has been called to an article read before the "American Pediatric Society," at Boston, May 4th, 1892, by Professor A. Jacobi, M. D., and published in the December number of *The Archives of Pediatrics*. This article is entitled, "Note on Peroxide of Hydrogen," and purports to be a "warning."

The learned writer endeavors to convey the impression that, peroxide of hydrogen (medicinal) is a "nostrum," and that the manufacturer of this article is to be classed among "quacks and patent medicine vendors."

Dr. Jacobi mentions several cases of diphtheria, which having been apparently greatly relieved by the use of peroxide of hydrogen (medicinal), finally were cured under the use of lime water, as a spray and wash.

The inference drawn by the writer of the article in question is, that the peroxide was an "irritant" and had been of more harm than good.

It is not my province as a chemist to enter into a medical discussion with the learned doctor but I would like to ask if, in his opinion, a case of diphtheria can be treated successfully with lime water only, and whether in the cases he cites, it is not possible that the peroxide treatment was an important element in the recovery of these patients. I would also inquire whether the intemperate and in some instances personal allusions to myself and the preparation which I manufacture, are in all respects the outcome of professional investigation, and not the result of a desire to advertise himself by discrediting a remedy of which the therapeutic value has been proved by thousands of physicians who, though they may be "unsophisticated" from Dr. Jacobi's standpoint, are nevertheless known as eminent and honored professional men, all over the world.

The drift of this article is seemingly an attempt to prove that peroxide of hydrogen (medicinal) is injurious.

In confutation of this, I append herewith, in as concise a manner as possible, the experience of a few prominent physicians whose statements may be taken as conclusive in the sense that they are

learned and talented professional men, the equals of the writer who challenges their experience after having undoubtedly read their opinions, for every word I quote here has been published, and forms a prominent part of the medical literature of the day.

In confirmation of my sincere belief that the claims made by me of the harmless character of my medicinal peroxide of hydrogen are true, I am willing to submit myself to a thorough test upon my own throat by spraying it with a twenty-five per cent. solution of Marchand's, peroxide of hydrogen (medicinal) instead of a five per cent. solution as alleged to have been used by the doctor, for the same continuous number of days mentioned by him; and if any ulceration appears, or if the repeated applications of the remedy "does give rise to actual diphtheria," as he states may be possible; then I am willing to acknowledge that he is right. This test may be made at any time with the utmost publicity.

I make this proposition in good faith from a scientific standpoint, and will expect Dr. Jacobi to make the test in the same spirit or acknowledge that he does not desire to do so.

## THE LIBRARY TABLE.

*A Handbook of the Diseases of the Eye, and Their Treatment.* By Henry R. Swansy, A. M., M. B., F. R. C. S. I. Fourth edition with illustrations. [Philadelphia: P. Blakiston, Son & Co., 1892.]

That the third edition of this work, published in October, 1890, should have been exhausted within two years and a fourth edition called for, is positive testimony to its value. Although it is a small book compared with many similar treatises, the information contained in it is so well selected that one reads it with satisfaction. It is not so elaborate as to be wearisome, yet it is complete enough for a guide to the general practitioner and, in many instances, is sufficient for the specialist. The work possesses a distinctive character. It is the production of a mind capable of appreciating the essentials of Ophthalmology, together with the ability to present them in a clear and forcible manner. This fourth edition has been revised throughout and brought up to date. New means for accurate diagnosis are fully explained, and new remedial measures are described in detail.

While there is no endeavor to present a systematic account of the anatomy and physiology of the eye and its appendages,

there are several interesting references to the results of recent investigations in these departments. Instances of this occur in Chapter xi, devoted to "The motions of the pupil in health and disease;" and in Chapter xviii upon "Amblyopia and amaurosis due to central and other causes." Two colored diagrams of "The course of the optic fibres, with the centres of the three visual perceptions, and relations to fields of vision," illustrate the two theories of the macular nerve supply. One is that each macula is innervated from the opposite hemisphere; and the other, that the macula is supplied on the same plan as the rest of the retina, i. e., each side from the corresponding side of the brain.

The subject of treatment of the various diseases of the eye has received careful attention throughout the book. Granular ophthalmia is referred to at considerable length, and the various methods of treatment are fully given. Squeezing out the granulations by means of Knapp's roller forceps is very favorably mentioned.

A caution is given as to the use of jequirity, the author concluding his remarks upon it by saying that "the presence of well marked pannus of the cornea



without ulceration is, I think, the only thing that can render the employment of jequirity justifiable, and, in addition to this, the conjunctiva should be free from blennorrhoea."

In the treatment of corneal ulcers he does not write very enthusiastically of the use of miotics. He considers that they increase the tendency to iritis. Referring to the modern method of thoroughly cocaineizing the eye before proceeding to operate for extraction of cataract, he says, that previously to the introduction of cocaine, general anaesthesia with ether or chloroform was commonly employed in England. I never used it." He insists upon careful attention to antiseptic measures, before and during the operation. He presents a very careful description of the "Three millimetre flap operation" for cataract extraction in which iridectomy is performed. In his defense of this "combined method," when discussing the subject of "Cataract Extraction without iridectomy," he says, "whilst admitting the charm of a circular pupil, I am of the opinion that the question is not whether the appearance of the eye is pleasing to us and to those who inspect them, but rather what advantage the greatest number of persons operated on derive from the operation. With sentimental talk about mutilation of the iris I cannot pretend to sympathize."

In an appendix Holmgren's method for testing the color sense has been described in greater detail than before.

Swanzy's Handbook bids fair long to hold its place upon the tables of our libraries.

*A Manual of Clinical Ophthalmology.* By Howard F. Hansell, M. D., and James H. Bell, M. D., with 120 illustrations, pp. 231. [Philadelphia; P. Blakiston, Son & Co., 1892.] Price \$1.75.

The authors preface this manual by stating their purpose "to place before the undergraduate and general practitioner of medicine, a brief review of the anatomy, physiology, refraction, and common diseases of the eye." Right well have they performed their work for we rarely meet with a book which contains so much accurate and valuable information condensed into so small a space.

The first part contains a succinct account of the general Anatomy and Physiology of the eye. This is followed by other sections on Physiological Optics, Refraction, and Ocular Muscles. The remainder of the book is devoted to Diseases of the Eye and to Operations.

Although the description of each disease is concise, it is sufficient for recognition; and the treatment is shortly but emphatically given. There is no redundancy. All information is of the most practical character.

This book of 231 pages contains no less than 120 illustrations. As the authors frankly state, none of these are original, but their value has been greatly enhanced by the care which has been exercised in their selection and the excellent manner in which they have been reproduced.

To the undergraduate and general practitioner, for whom it is prepared, it will prove

an excellent introduction to more exhaustive treatises on the subject. One recommendation is the low price at which it is published.

*Appendicite et Perityphlitis, Ch. Talamon; Pleurisies Purulentes, Debove et Courtois-Suffit; Le Rachitisme, J. Comby.*

Dr. Talamon has written for the "Bibliothèque-Médical Charcot Debove," an excellent monograph on "Appendicitis and Perityphlitis." He discusses the history of the observations from the case published by Negeler in 1813, to the latest histories and operations of Treves, Oppenheimer, McBurney and Keen. Melier in 1827, suggested the wisdom and possibility of operation and reported three cases of perforating appendicitis. The whole subject is discussed intelligently with a thorough knowledge of the accumulated literature of the last ten years, and a useful if perhaps too minute plan of sub-division of the various forms according to the anatomical situation of the part primarily affected is suggested. The author insists, with Ashley of Baltimore, that unrecognized appendicitis is more frequent in woman than is supposed. The activity of American surgeons in this subject is well represented by numerous citations, and Dr. Talamon gives them full credit, while disagreeing with what he thinks a too strong tendency on their part to early operation in preference to the conservative medical treatment he would follow.

Another volume of the same series on the "Treatment of Purulent Pleurises" is by Debove and Courtois-Suffit. American surgeons have not so large a share here, and indeed scarcely appear at all. The authors have not written a polemic in favor of thoracentesis or lavage, but a calm discussion of the whole subject, with insistence upon the importance before operation of careful study of the individual case, especially by means of bacteriologic examination. "When we know the variety of empyema, the nature of the pathogenic agent producing it and the virulence of this agent, we can deduce the probable course of the pleurisy; but above all we can choose the most reasonable method of interference." The study is divided under three heads, the evolution of medical ideas on the subject, the different useful operative procedures, and the methods applicable to each variety of purulent pleurisy.

The third volume of the same series which bears the apparently necessary name of Charcot, is on "Rachitis," by Dr. Comby. This disease once fortunately uncommon among native whites in this country, is growing more frequent with the increasing pressure of our population. It is one of the maladies which has not been revolutionized by bacterial pathology, but the new interest in minute pathology and the new knowledge of the evolution, prophylaxis and treatment lends it interest. Like the other manuals already reviewed, this one is well up to the information of the day, and if on a matter of less active general moment, is none the less valuable for its clearness, simplicity and fullness.

*Curious Questions in History, Literature, Art and Social Life*; designed as a Manual of General Information. By S. H. Killikelly. In two volumes. Philadelphia: The Keystone Publishing Co., 1892.

This is a valuable work. Nearly 600 questions are propounded and answered. Probably not one-twentieth of these questions could be answered off-hand and correctly by the best-informed person in any ordinary community. How many readers know: "What noted warrior led his troops into battle after his death?" "What kind of a tub did Diogenes live in?" "What is the Key of Death?" "What city was destroyed by silence?" "When was ecstasy an infectious disease?" These sample questions selected at random, are answered fully, but not fulsomely.

It is a work for cultivated people, and the amount of useful information to be gained

from its pages will amply reward the purchaser.

The paper is good and the type clear and legible. "Curious Questions" is bound in two styles; one in dark green cloth, the other in half morocco. The latter style is illustrated.

*Medical Journal Advertising: A Manual for Advertisers.* Edited by A. L. Hummel, M. D. Price one dollar. Published by Hammel & Parmele, 612 Drexel Building, Philadelphia, 1892.

Intending advertisers will find much of value, and all will be interested, in this book. A number of men, prominent in medical circles, contribute articles of real value. It is an educating book in the sense of showing the benefits of advertising, and in teaching the advertiser how to word and place his announcements to the best advantage.

## CURRENT LITERATURE REVIEWED.

### PACIFIC MEDICAL JOURNAL.

Dr. Fred. W. D'Evelyn contributes a paper on "The Right Heart in Circulatory Obstruction," in which he cautions against the use of digitalis and its fellows in those cases where the right heart is engorged, and the left side really depleted through the venous engorgement and lack of arterial blood.

Dr. A. W. Perry, in his article on the "Surgical Treatment of Puerperal Endometritis," advises the use of the curette followed by an antiseptic douche in puerperal sepsis, especially those cases where there may be retained portions of placenta or membranes.

The number concludes with an account of "Receiving Hospital of San Francisco," by Dr. Tenison Deane. The hospital is under the charge of the Board of Health, and has accommodations for about twenty patients besides a ward for alcoholic cases. A surgeon is constantly in attendance; fractures are treated; fractured skulls are trephined; laparotomy is done for stab and gunshot wounds. "In fact every conceivable injury is treated at the hospital during the year."

### VIRGINIA MEDICAL MONTHLY.

Dr. J. M. Baldy's article on "Uterine Fibromata" gives his experience in hysterectomy. He has removed twenty-seven tumors with two deaths. He pursues the supravaginal extra-peritoneal method, and commends that as being the most uniformly successful.

Dr. John Dunn reports two cases of "Congenital Chorea." Dr. N. L. Guice reports a case of "One-sided Swelling of the Face," as the result of malaria.

Dr. William C. Dabney contributes a clinical lecture on "Valvular Disease of the Heart," and defines the indications for digitalis in such cases. There is also a report of a "Aneurism of the ascending arch of the Aorta," by Dr. Llewellyn Elliot. "Dysen-

tery, Its Prevalence and Treatment," is the title of a paper by Dr. L. Ashton. Dr. George Corrie describes an improved "Urethrotome," made after the well known Otis instrument, but differing from it in having a bulb at the distal end of the upper bar of the shaft, which, Dr. Corrie claims, besides sheathing the knife, "defines the tissue to be cut, avoiding the annoyance and uncertainty of having to take measurements." There is also an indicator attached which shows accurately the movements of the blade.

Dr. Chas. G. Cannaday advocates the use of the galvanic current, with faradization, as a "Uterine Developer," giving the report of two cases treated in this way. He claims that, by this method, the uterus is stimulated to take on new growth, the menstrual functions are restored, and dysmenorrhea and sterility cured. [Tonics and carefully regulated hygiene are also part of the treatment and, in the minds of some, will be accredited with the improvement noted and not the electricity.—Ed.]

### MONTREAL MEDICAL JOURNAL.

Dr. W. Johnson reports a case of extensive fracture of the skull as the result of a "Gun-shot wound through the orbit." The report is interesting from a medico-legal point of view and Dr. Johnson gives the result of several experiments on the cadaver, made to show the injuries on the skull that would be received by the discharge of a load of shot through the orbit at close range.

Dr. Thomas R. Dupuis, in an article on "Goitre and its treatment," rejects surgical interference as likely to be followed, even if the patient survive, by cretinism and an enormous increase of mucin in the body or *myxœdema*. The various non-surgical methods of treatment are discussed and, while the disease is fortunately rare in this portion of the country, the article is worthy of attention as an addition to our knowledge of the subject.

Dr. J. A. Springle reports a case of "symphysiotomy," performed for contracted pelvis. The forceps had been applied and failed to deliver. After division of the symphysis, forceps were again applied and a living child delivered. The number also contains an address by Sir James Grant, M. D., on "Queen's University and Medical Education."

#### THE PHILADELPHIA POLYCLINIC.

In the January number of *The Philadelphia Polyclinic* Dr. Baer calls attention to "The Danger of Delay in Pelvic Abscess." Dr. Roberts offers a few remarks on "The Pathology and Treatment of Internal Hemorrhoids."

Dr. Contrell having witnessed many mistakes in the diagnosis of the two affections, "Psoriasis and Syphilis," presents one case of each with a study of several features which are prominent in each.

#### ARCHIVES OF PEDIATRICS.

The January issue of the *Archives of Pediatrics* contains an interesting discussion on "The Relation of Rheumatism and Chorea" by Dr. Townsend of Boston, Dr. Crandell of New York, and Dr. Adams of Washington, of which fuller mention is made elsewhere.

#### Types of Infantile Syphilis.

by Dr. Stowell, is deserving of a careful reading. In the treatment of these cases, he states that he has "fallen into a habit of using what proved good." Inunctions of oleate of mercury for infants, with mixed treatment to the mother, if nursing. Older children, especially in late manifestations, were given mercuric chloride in doses ranging from 1-120 to 1-32 of a grain according to age. Mercury we find lauded in all forms. Calomel or grey powder is easily administered, but at times proves too laxative unless checked by an opiate. Inunctions of two per cent. of oleate of mercury, or of the officinal ointment, are better than internal medication. Judicious feeding and general tonics must not be forgotten, for the evil is only removed by constant and long continued vigilance.

A clinical lecture by Dr. A. Jacobi on "Multiple Sarcoma," and "Hydrocephalus" completes the list of the more important papers. This number also contains an open letter from Mr. Marchand in protest to strictures upon Peroxide of Hydrogen made by Prof. A. Jacobi, in a former issue of this journal.

#### JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

For January the leading article offered is a new and successful mode of treatment in "Xanthoma Tuberculatum" by Dr. Morrow. It is illustrated by a chromo-lithographic plate which is of great assistance in elucidating the subject.

#### Dr. Blanc reports

#### A Case of Skin Shedding.

in which the epidermis of the hands and feet, particularly the former, came off almost without a break, resembling gloves and moc-

casins. The nails were loose but did not come off at this time. The doctor believes that while, from the general character of the case, this is not a true type of *dermatitis exfoliativa*, yet it resembles it sufficiently to be a variety of it.

Dr. Hartzell has a carefully prepared paper on "Sarcoma Cutis." The subject matter is well illustrated.

#### THE BRITISH JOURNAL OF DERMATOLOGY.

The Journal of Dermatology for January contains but one article and that a monograph by Dr. Stephen Mackenzie, on

#### Dermatitis Herpetiformis

which is defined as a cutaneous neurosis characterized by the multiformity of its manifestations, which may consist of erythematous, papular, vesicular, bullous, and urticarial eruptions, which may appear concurrently or consecutively and are usually attended with pigmentation of the skin; a grouping of vesicles is the most characteristic feature, and present in most cases at some part of their course; it is usually attended with great itching and burning; it runs a chronic course with exacerbations, or relapses and intervals, and usually terminates spontaneously, but may end fatally; it is attended with some, but usually not serious, disturbance of the general health; it affects both sexes, and at all ages, but is most common in the middle period of life; in women it is often connected with pregnancy, but may occur independently of it." It is not surprising that such a polymorphic disease should have received a variety of names. The author has adopted the present name, given the disease by Dr. Duhring, which seems the most generally accepted, as it is the most descriptive.

#### Neuroses after Removal of Appendages.

Debove (*Nouv. Arch. d'Obstet. et de Gynec.*, 1892) demonstrated at a recent meeting of the Societe Medicale des Hospitaux that removal of the appendages may do worse than fail to cure hysteria and pelvic pain. It may fail to prevent, and may even excite, a neurosis. A woman, aged 38, had her appendages removed in December, 1889. The ovaries were found "diseased." Her period did not recur. On June 28th, 1890, she had a severe nervous attack, which recurred. Debove examined her during one of the seizures. There was right hemianesthesia with the typical so-called ovarian pain in the iliac fossa. Thus this symptom may exist when no ovary remains. Compression over the region set up an attack, and the pain could be transferred by the application of magnetism. Desnos, in discussing the case, stated that he had twice seen insanity after ovariectomy. Rendu noted that many abdominal operations were followed by the same result. He saw insanity commence in a woman a few days after an operation for artificial anus. The mental disease proved incurable and fatal. Mathieu had seen nymphomania after removal of the ovaries.—*Br. Med. Jour.*



## PERISCOPE.

## THERAPEUTICS.

Dr. H. A. Hare (*Therapeutic Gazette*) recommends strychnine as a remedy for and the prevention of surgical shock, anæsthetic collapse and opium-poisoning. He states that it must be given in full doses or not at all. Not less than a twentieth of a grain should be used hypodermically every half-hour for an adult; and if the shock be marked, a dose of as much as a fifth of a grain may be given in this way. Disagreeable effects rarely follow, and will probably amount to no more than muscular twitching, which can be readily controlled by sedatives. In describing a visit to Professor Horsley's laboratory, he says that a monkey upon whom a brain experiment was being performed was placed in a water-bath and well covered to attain the proper heat. This is considered necessary for the survival of the monkey, and from it may be inferred that the application of heat about the body of a person undergoing an operation is of the greatest importance. The same is also true in cases of hemorrhage and shock. Experiments by Brunton show that animals poisoned with chloral die from doses, which, when artificial heat is given them, fail to produce dangerous symptoms.

## MEDICINE.

## Actinomyces Hominis.

Dr. Justus Ohage in writing on this subject says that actinomyces in man is one of the so-called modern diseases, that is, its recognition, description and understanding are due to modern investigation and discoveries.

The first to recognize this disease was James Israel, in Berlin, in 1878. He published his observations in Vol. 74, *Virchow's Archiv*. Ponfick, of Breslau, gave a fuller description of it in 1879, and was the first to demonstrate that the disease in man was really due to a fungus, the actinomyces first discovered in 1877 by Bollinger in the jaw of cattle. Since then numerous observations have been published and this disease has obtained full pathological recognition. Actinomyces is more frequent in Europe than here, at least it is oftener diagnosed and recognized over there; still the disease is common enough in this country to demand the attention of the medical profession.

The disease is produced by the entrance of a vegetable parasite or fungus into the system. The raylike arrangement of its elements caused Harz to name it actinomyces, "aktis," ray, "mykis," fungus. The experimental researches of Ponfick, DeBray and Pringsheim have conclusively shown that this fungus is the true *causa morbi* of the disease in question, and have proved the identity of it in man, cattle and hogs beyond any doubt.

The diseases with which actinomyces is most often confounded are tuberculosis and

epithelial cancer. It gains its entrance into the system in various ways. The fungi may enter with various kinds of food, by inspiration, etc., and according to the channels through which they entered the system the symptoms of the disease make themselves manifest. We have thus actinomyces of the lungs, the kidneys, the bowels, the stomach, etc.

Most cases of actinomyces in man have their starting point in decayed teeth and diseased tonsils. From here the fungus is distributed through the organism and begins the destruction of the organs on which it has settled. The protean character of this disease is indigenous to man only, while in the lower animals, cattle and hogs, its predilection is for the jaw. There is another peculiarity—the tendency to the formation of tumors in animals is entirely absent in man. On the contrary, the granular tissues produced by the phlogogenous action of the fungus tend to fatty degeneration and decay. In an insidious and chronic manner the fungi penetrate the tissues, destroying them in their onward march, and unless the perforation of some vital organ as the stomach, or the bowels, or the lungs cuts life short, the mode of death is generally that by pyæmia.

The diagnosis of the disease during life is comparatively easy if the ravages of the fungus are visible to the eye, as in the first two cases which I shall presently describe. A peculiar form of small yellow bodies is always found in the pus, fistulæ and swellings; it is unmistakable after once having been seen. On microscopical examination they seem to consist of threads terminating in bulbous ends. The threads radiate from the centre, thus giving the fungus a ray-like appearance.

When internal organs are attached, hidden from view and inaccessible to observation, the diagnosis is impossible.

The prognosis and treatment of actinomyces is based upon its indigenous properties. As it is a local fungus disease, not constitutional like syphilis and tuberculosis, it is curable if all the infected tissues can be removed. Where that cannot be done a fatal termination is inevitable.—*Northwestern Lancet*.

## Aural Symptoms of Neurasthenia.

Dr. Suney Molist (*Annales des Mal. de l'Oreille*, Dec., '92) offers an explanation of the annoying symptoms, in the form of subjective noises, which are so prominent in many cases of neurasthenia, and which are accompanied often by a considerable diminution of the hearing by bone conduction. These cases of tinnitus are grouped by the author as follows:

(1) Simple suspension of vaso-motor inhibition of the vessels of the cochlea, which, by their pressure upon the terminations of the acoustic nerve, cause a continuous tinnitus, which may be temporarily relieved by forcible compression of the carotid.

(2) Patients who have previously had an

otitis, who are rheumatic subjects or who have an atheromatous condition of the vessels which once dilated do not readily return to their previous condition, the result of this continued dilatation being exudation into the membranous labyrinth or, possibly hemorrhage.

(3) Affection of the perceptive power of the internal ear as the result of the long continued vaso-motor disturbance; in these cases the tinnitus gradually increases in intensity, as does also the impairment of hearing, and to these two symptoms is sometimes added vertigo.

According to Rampoldi (*Annual Univ. de Med.*), there are five groups of sexual diseases which affect the eye, as follows:

(1.) Hysteria and chronic metritis are causative of asthenopia and retinal hyperaesthesia.

(2.) Menstrual disorders. Amenorrhoea is causative of conjunctivitis keratitis, iritis and phlyctenulae. To suppression of the menses he refers diseases of the choroid, with neuritis and retinitis. The tendency to glaucoma is known to accompany a sudden suppression.

(3.) Inflammatory diseases occur in hyperaesthesia and neuralgias of the trigeminus.

(4.) Pregnancy causes the difficulty accompanying the albuminuria of that state. Amblyopia and amaurosis have been common from three to fourteen days after hemorrhage.

(5.) During lactation and the puerperium the following have been observed: Panophthalmitis, ulcers of the cornea, retinitis, photophobia, disturbances of accommodation and other morbid conditions resulting from debility.

#### Discriminating Diagnosis Between Cerebral Hemorrhage and Acute Softening.

##### CEREBRAL HEMORRHAGE.

1. Age, thirty to fifty.
2. Hereditary history of arterial disease.
3. Sudden onset with coma and paralysis occurring together, the coma deepening.
4. Stertorous breathing, and hard, rather slow pulse.
5. Peculiar alternate conjugate deviation of the eyes.
6. Early rigidity.
7. Convulsions.
8. Initial subnormal temperature followed by a rise in twenty-four to forty-eight hours.

##### ACUTE SOFTENING.

1. Earlier or later age.
3. Premonitory symptoms and more gradual onset or more transitory coma.
6. Rarely occurs.
7. Seldom present.
8. No initial fall of temperature. But slight tendency to subsequent fever.
9. Presence of weak heart or endocarditis. Slight hemiplegia with aphasia. The puerperal state.—DR. DANA.

## SURGERY.

Dr. Darrah (*Boston Med. and Surg. Jour.* Jan. 12, 1893) in a report of three cases of caries of the coccyx draws the following conclusions:

(1) That caries of the coccyx occurs very infrequently.

(2) That it is more common in females than males.

(3) That there are these important points in considering the diagnosis of these cases: (a) history of injury; (b) constant pain; (c) multiple and persistent sinuses (not always present); (d) that persistent sinuses should lead one to suspect caries of the coccyx; (e) that excision of the coccyx is the best treatment for all cases when there is disease of that bone.

#### The Early Extirpation of Tumors.

In a paper read before the New York State Medical Association, at its recent meeting, Prof. J. W. S. Gouley presented the following conclusions on this subject:

1. Malignant tumors exceed benign tumors in frequency.

2. That malignant tumors comprise epitheliomata, sarcomata and internal adenomata.

3. Among the benign tumors myxomata and external adenomata often recur after incision, but do not infect the system.

4. There is no solid benign tumor that may not become malignant.

5. No means are known by which can be ascertained the precise time of the beginning of metamorphic action in tumors.

6. Most malignant tumors have a stage of benignity.

7. Excision of potentially malignant tumors in the early epoch of their stage of benignity is likely to effect a permanent cure, or at least to prolong greatly the period of immunity from recurrence of the disease.

8. In the excision of malignant tumors the greatest care should be taken to remove as much of the ambient tissue, including fasciae and lymph glands, as is compatible with good judgment.

9. General treatment of tumors has no value except as an adjuvant of a surgical operation, and is often indirectly injurious, leading the patient to expect a cure by persevering in the use of drugs, and thus allowing the disease to make rapid progress toward a fatal end.

10. Local treatment of tumors, by means of escharotic plasters, pastes or powders, is the most fruitful in evil of all the devices for the torture of the afflicted. The plaster, paste or powder causes the greater part of the tumor to slough, but there is enough left behind for the most rapid extension of the disease. The effect of the escharotic is, therefore, only to till a soil where new growths sprout like so many seeds cast upon a rich loam.

11. Compression is delusive in the case of tumors containing cysts, and is directly hurtful by exciting the rapid growth of most tumors.—*At. Med. and Surg. Jour.*

### Treatment of Aortic Aneurysm by Electrolysis through Introduced Wire.

Stewart (*Amer. Jour. Med. Sci.*, October, 1892) reports a case of large sacculated aneurysm of the aorta treated by the introduction of wire and electrolysis. This treatment was tried with the object of promoting prompt formation of firm protecting coagula, in order to retard rupture of the thin-walled sac. The aneurysm, which had arisen from the lower part of the thoracic aorta, and subsequently had involved a portion of the abdominal aorta, was a very large one, and bulged backwards so as to form a prominent pulsating swelling in the left lumbar region. The patient was a man, aged 32. In his operative treatment of this case the author chose a rather heavy silver wire with the idea that the presence of large supporting spirals in the sac occupying much of the cavity, and affording a good framework for clot, would offer a better chance of immediate success than the use of a thinner and more pliant wire, which might undergo deflection from its course of introduction through coming in contact with loose coagula already in the sac. Two and a half feet of wire and also one end of a platinum needle were introduced into the sac, and a current, after being gradually increased to a strength of 70 milliamperes, was maintained at this point for one hour. The wire was passed through a canulated steel needle two and a half inches in length. The condition of both needles on withdrawal showed unquestionable clot formation about them.

On the third day from the date of operation a remarkable change was noticed in the condition of the aneurysm. The prominent pulsating portion in the left loin had become depressed, and transmitted pulsation could be detected in it. The whole of the lower part of the aneurysm felt much firmer, and was quite without pulsation, while the extreme upper part seemed to have undergone no change. The patient, however, continued to suffer severely, and, on the ninth day, died very suddenly in consequence of the rupture of the sac. At the necropsy firm clots were observed in all portions of the aneurysm, together with soft ones evidently of very recent origin. The wire was engaged in several large firm clots, which were of so solid a texture that when examined in that part of the sac which was removed they could not be separated from the sac and wire without some difficulty.

### OBSTETRICS.

#### Asepsis and Antisepsis in the Lying-in Chamber.

Potter makes the following propositions concerning asepsis in the puerperal chamber.

1. Let us begin by making the patient as nearly clean as possible for soap and water to accomplish.

2. Let her, prior the beginning of labor, have an immersion-bath daily for several days,

and with the first manifestations of pains, let her abdomen and genitalia be rendered absolutely aseptic by further application of germicides in solution, adequate to accomplish the desired end.

3. Let her have a warm vaginal douche, rendered aseptic.

4. Let the lower bowel be thoroughly evacuated by copious lavements of hot water prior to the vaginal bath.

5. Let her bedding be made as pure and clean as careful laundrying can make it.

6. Let her clothing be made equally clean in like manner.

7. Let there be a number of clean bichloride napkins placed in readiness for use.

If all of these injunctions are rigidly enforced, we have done much to lay the foundation for a physiological labor.

The physician and all the attendants must be rendered as scrupulously aseptic as the patient herself. The nurse must be especially trained in the habit of keeping her hands clean. After the first examination, which should be made as carefully and deliberately as possible, the physician should refrain from further examination unless absolutely required.

#### Suckling and Quinine.

Oui (*Arch de Tocologie et de Gynec.*, December, 1892) finds that when the mother or nurse takes quinine it has no ill effect on the child. The drug is certainly excreted with the milk, but in very small quantities. The quininised milk has absolutely no influence on the child. After a series of careful weighing and measurement, it was found that the average was the same in children suckled for a given time by nurses who had taken quinine as in children whose nurses had not taken that drug. Hence a nurse or mother may safely take quinine. Burdel's theory that quinine is noxious to the child is incorrect, and the precautions which he recommends are therefore unnecessary.—*Brit. Med. Jour.*

#### Missed Abortion.

Liebmann, of Buda-Pesth (*Centralbl. f. Gynak.*, No. 38, 1892, from the *Arvost Hétlap*), relates a case in which the remains of a foetus which had died in *utero* were discharged piecemeal. A three-para suffered at the fourth month of pregnancy from a foetid sanious discharge, which lasted for two weeks; then pieces of foetal bone began to come away. The process took about seven months, with intervals corresponding to the greater or less strength of the uterine contractions. Some of the bones were discharged singly; some remained articulated and required forceps for their removal. The placenta came away four and a-half months after the beginning of the abortion. The number of bones that were thus gradually delivered amounted to over seventy, and indicated that the foetus had reached the third month.—*Ez.*



## GYNECOLOGY.

**Fatal Rupture of Pyosalpinx: Suspected Abortion.**

Rochet (*Journ. d'Accouchements*, 1892) recently described a case of rupture of a pyosalpinx from rough handling during the application of the curette to the uterine cavity. He adds a yet more instructive case. A female servant, aged 28, was admitted into hospital, losing blood. She fancied this might be due to a miscarriage at the first month, which she believed to have occurred on the previous evening. The uterus seemed normal. A tender mass of the size of a small egg, lay in Douglas's pouch. A few days later the patient insisted on leaving the hospital. She was therefore examined first; the mass was found smaller and less tender; at the time the examination caused no pain. Pyosalpinx was diagnosed, and the patient, instead of leaving the hospital, remained, and an enema with a dose of castor-oil was given in view of an operation. In the evening the patient became very ill. Next morning an exploratory operation was performed. Pus escaped freely when the abdomen was opened. Douglas's pouch was laid open and drained. The patient died in a few hours. There was a judicial inquiry owing to a suspicion that she had died from attempted abortion. There was no doubt that the cause of her death was rupture of a pyosalpinx. The uterus showed signs of recent early pregnancy. There was no evidence of criminal abortion. Rupture of a pyosalpinx is no doubt the cause of many mysterious deaths after curetting, dilatation of the uterus, etc., when the uterus is dragged downward, or pushed upward with violence.—*Brit. Med. Jour.*

## ARMY AND NAVY.

FROM JANUARY 15, 1893, TO JANUARY 21, 1893.

First Lieutenant Thomas U. Raymond, Assistant Surgeon, is relieved from further duty at Vancouver Barracks, Washington, and will report in person to the commanding officer Fort Canby, Washington, for further duty at that station, relieving Captain Edward C. Carther, Assistant Surgeon, who on being thus relieved, will proceed to Vancouver Barracks, and report in person to the commanding officer of that post for duty there.

Captain Guy L. Edie, Assistant Surgeon, U. S. Army, is relieved from duty at Fort Nebrara, Nebraska, and will repair to New York City, New York, and report in person to the attending surgeon in that city, for duty in his office.

Leave of absence for four (4) months, is granted Captain Jefferson D. Poindexter, Assistant Surgeon, U. S. Army.

## NEWS AND MISCELLANY.

**One of the Ways by which Corporations Reduce the Income of the Medical Profession.**

In general it may be said corporation exist to reduce to the lowest possible degree the incomes of all with whom they deal. On former occasions we have called attention to the effect of railroads upon the income of surgeons. But just now we desire to call attention to the influence of accident insurance companies in diminishing the income of the profession.

Formerly when one of the employees of a manufacturing establishment was injured, either the employee called upon his own doctor or the company sent him to a well known practitioner. After recovery, either the man paid the doctor what he was able to, or the company paid the bill. In either case the doctor got a reasonable reward for his work and responsibility. Lately companies have been formed that agree for a certain sum to look after the injured employees. The results of this plan are that the accident company deliberately sets about to cheat the doctor out of his fee for service. It employs men adapted for this particular purpose. If they fail in other ways, they dump the patient into the charity ward of a hospital, paying his board and making the hospital doctor do the work for nothing. In the aggregate the money thus lost to the profession and put into the pockets of the accident insurance company is very large.

In this case we do not see any way by which this leak can be stopped, because all doctors, will not combine to prevent it. In a different form, it is the same as with the railroad doctors. All will not agree in refusing to do the work without fair compensation. In each case, if one refuses, another takes his place on the terms offered by the corporation. In the contest between doctors and corporations, the latter take the money and keep it, while they leave for the doctor all the glory.

As to the benefit to employees, the following is significant. The writer, observing a dangerous condition of a freight elevator, directed the attention of the proprietor to it. He carelessly replied that it made no difference to his house, as a casualty insurance company was paid to protect the firm from all damages.—*American Lancet*, Nov. 1892.

**Popular Tours to Washington.**

Personally conducted tours to Washington have been arranged via Royal Blue Line, to be run at frequent intervals from New York and Philadelphia to Washington. The next excursion will be on February 2nd. For programme describing these tours, write to Thos. Cook & Son, Agents B. & O. R. R., 281 and 1225 Broadway, New York, or 332 Washington Street, Boston.

FEBRUARY 4TH, 1892.

## THE MEDICAL AND SURGICAL REPORTER

MONOGRAPH SERIES. No. 1.

## SEXUAL FUNCTION AND INSANITY.

JOSEPH PRICE, A. M., M. D.,  
PHILADELPHIA.

The growing circle of comparatively young, yet earnest men of the profession, welcome the awakening of an epoch in medicine and surgery. Our chief pride is that the decree is spurned which would determine for us that we have exhausted the resources of our science and art. There is herald of greater victories than yet gained in the fact that we will not brook servility to the traditions of an ended age. We will tolerate no bondage to the theories of the best genius of the past. They made soil for us in which to plant the seeds of new growths and to the cultivation of which we will apply our improved methods. Time and progress make "an ancient good uncouth." We have no time nor spirit for listening to echos. Let those who love to cling to apron strings, (Paps' Boys), play innocently amid Ancestral shadows, but let there be no restraint upon the impulse, the rugged purpose of those who would have a freer atmosphere for our advances, a larger firmament, and a new and more promising future.

For centuries insanity, even by the most eminent scientists, was considered only from a psychical standpoint. Even yet the alienist insists that you cannot restrain, change or give different direction to these psychical processes, that they are peculiarly and exclusively of the brain—that both cause and effect are prisoned within the cranium. He obstinately refuses to recognize that there is much wrapped up in the mysteries of insanity which the gynecologist could aid him in unraveling. Gynecology is not a branch the Alienist cultivates and he is slow and reluctant to receive its stern lessons. It

has been only within the last decade that the bolder, more progressive spirits of the profession have entered into this forbidden field.

We are not at all disposed to question the existence or underestimate the force of psychical influences. Our human science fails to reveal to us their occult working, yet they have for us many lessons worthy of profound study. Nor would we set up the claim that surgical interference will effect cure in all or even the majority of cases where there is disease of sexual organs, but we feel assured that it will in many.

We have a right to expect much in the future from our present and rapidly growing knowledge of the pelvic organs and their functions. We will grow to even better knowledge when to interfere with the pelvic organs and when to let them alone. Diagnosis is not perfect. Even with those with the most successful experience there will continue to be mistakes, but our art has and will continue to improve with the broadening of our experiences. Cases are rapidly multiplying that sustain the claim that a great number of cases of insanity in women can be relieved and absolutely cured by gynecological treatment. We have great numbers coming to us every day with their disorders and sufferings who go away cured, and by every right and claim of humanity the insane are entitled to have the same relief extended to others—if not for mental cure for the relief of physical suffering. They should not be permitted to suffer double afflictions, mental and physical.

Allow for all the factors that face upon us as the chief promoters of mental disturb-

ances and still there remains in very many cases unexplained causes, unless we take into account diseased physical organs. Conclusions from mere psychical phenomena is not satisfying and does not lead to advances in the line of treatment.

That there are causes of insanity outside the cranium is no longer a controverted question among scientific men—those who have given the subject studious, scientific investigation; those who have studied the relation of disease to mental conditions. That there is not more light upon the subject, more relief given and cures effected in our insane asylums is largely due to the inertia, if not indifference, of certain Hospital Authorities.

There is always in such bodies a little biped, jumping-jack minority, who will travel more miles for a good dinner at the expense of some charity, than they will feet for a practical idea or to carry forward some practical and humane work. They will not do themselves, nor let others do, who have a high appreciation of official and professional duty—an intelligent and conscientious sense of the responsibilities of their work. The physicians in charge of these hospitals are usually men and women of tested ability, of noble aims; but there is too much put upon them, both of work and responsibility, and they do not receive that moral support and encouragement they should in a work that tests every faculty of mind and every element of bodily strength. The need is of more help, both of skilful physicians and trained nurses. When there is neglect it is not generally the fault of those in professional charge, their duties are too many and too varied for them to efficiently discharge them all with that completeness which is due to these unfortunate sufferers.

Fitness by thorough education in special lines is not enough considered. This should apply as well to nurses as to medical attendants. The victims of mental maladies require at all times either medical or surgical treatment, and at all times careful, expert nursing. In few other kinds of nursing is there such urgent need for special training.

The work is not one eagerly sought after. It is taxing, bodily and mentally; it is a work in which those employed

grow into expert discharge of their duties.

And let me add that very few gynecologists would be specially ambitious to exercise their calling in a lunatic asylum. In no other sphere would there be such weight of professional responsibility, such a burden of anxiety, such need for sleepless watch. These sadly diseased people are, so far as their legal or other responsibility goes, but children; they are the child-wards of the State. This fact greatly augments the responsibility of those made officially their care-takers. There should be a gynecologist, oculist, and other important specialists represented in each and all these institutions. The field of needed treatment is too broad for any one man's mastery. It has been demonstrated that the gynecologist can aid in restoring many of these unfortunate victims of the most dire calamity that can befall one of our human kind to complete cure or to better mental balance by the surgical treatment of diseased organs. They understand the causal relation accidents incident to parturition bear to disturbances of the nervous system. It must be recognized that there are troubles without the domain of medicine and within that of surgery, requiring surgical means of investigation and surgical means of treatment.

Dr. Thomas Savage in an address delivered in the obstetrical section of the British Medical Association says: "There is one more point I should like to refer to, and that is the necessity that exists for most and certainly all large lunatic asylums, to have a gynecologist as a member of their medical staff. Among the causes of insanity in women, heredity, intemperance and the vicissitudes of female life are said to be most frequent, and it has occurred to me, as I know it has to others, that in regard to the latter element as a cause, much good might result if every case in which there was the least doubt, were thoroughly overhauled and investigated by an experienced gynecologist."

There can scarcely be any dispute of the statement that there are now a large number of child-bearing women confined in our insane asylums into whose condition no special inquiry has been made. Their trouble has loosely been regarded as simply one of loss of reason or mental



balance without a moment's inquiry as to primary causes. Uterine and ovarian disease are quite as common in this class as among the sane. Unfortunately as yet we have found no class exempt.

With the view of throwing light upon the subject, a subject that, by virtue of its grave importance, needs all the light that can be thrown upon it, we will give a consensus of the opinions of the most eminent men of the profession of Europe, in connection with those of our own country who have given the subject the most careful, thoughtful, patient and laborious inquiry.

Dr. Barnes, one of the most eminent surgeons of England, formulates the three following questions:

- (1) Did the sexual disorder declare itself first?
- (2) Did the nervous disorder declare itself first?
- (3) What are the mutual reactions of these two disorders?

And if we trace antecedence of the sexual disorder, can the nervous disorder be traced to the sexual as a cause, or *vice versa*? These questions place the subject in line of direct and intelligent inquiry and open a very wide field of scientific and clinical study.

So very valuable do we consider Dr. Barnes' very thorough study of the subject that we shall quote freely from one of his very able papers, satisfied that his conclusions are of great practical value and will serve an educational purpose, do much to enlighten that class of alienists whose prejudices are stronger than their reasoning.

Dr. Barnes says: "Even if not directly causative, serious sexual disorders cannot fail to be an aggravating factor of the nervous disorder. It must be granted that no satisfactory solution can be attained without bringing to the inquiry thorough all-round diagnostic skill. Before recent advances of gynecology, women sane and insane had to suffer from ills now known to be curable. In studying the correlations of mental and sexual phenomena, we are struck by the double light thrown upon the problem by the application of surgery. The immediate design of surgery is the relief of suffer-

ing. Gynecology is largely surgical, and the true solution of its most important problems is revealed by direct appeal to surgery. It teaches physiology, the rational basis of the healing art; it demonstrates pathology at the same time that it heals. The surgeon learns, the subject gains life and health. Has this enlightening and beneficent surgery been fairly applied to the study of the physiology and pathology of women, or to the relief of women secluded in lunatic asylums.

When a complicating factor intervenes, as neurotic diathesis or disordered action of the sexual organs, the equilibrium is lost, and nervous disease may be provoked. If we pass to the neurosis that attend morbid conditions of the uterus and ovaries we get even more striking evidence of causation.

A frequent state is displacement of these organs, not necessarily diseased in tissue.

The most common is retroflexion or retroversion, with or without prolapsus of the uterus. These can hardly exist without entailing some disorder of menstruation, and this is enough to disturb the nervous equilibrium. But in addition to this, the displaced organ presses upon other organs, as the bowel and bladder, impeding their functions, and especially if it presses upon the sacral plexus, and so causes constant irritation of the lower segment of the spinal cord, a part of the nervous system, as we have seen more highly organized than it is in the male. So-called sympathetic, reflex or diastolic phenomena are frequent. In not a few instances these minor nervous disorders culminate in melancholia and mania. I have the history of cases in which the subjects had been insane for long periods, with no sign of amendment until they came under my care. I discovered pronounced retroflexion with hyperplasia of the uterus. This being corrected by surgical treatment, rapid recovery ensued. In one most striking case the subject returned to her home, bore twins, and has since been in perfect physical and mental health. Dr. Bennington reports a case to the British Gynecological Society equally remarkable. Schweder Vander Kolk relates a

case of a profoundly melancholic woman who suffered from prolapsus uteri, in whom the melancholia used to disappear directly the uterus was restored. Fleming mentions two similar cases in which the melancholia was cured by the use of a pessary, in one of them returning whenever the pessary was removed. In one instance, says Dr. Mandsley, I saw severe melancholia of two years' duration disappear after the cure of prolapsus uteri. It is probable that inversion of the uterus entails pressure upon the ovaries and disturbance of their function. Similar examples of nervous disorder have been observed in connection with displacement of the ovaries. Occasionally one ovary sinks down in Douglas' pouch, getting below the level of the uterus. Severe nervous symptoms follow, and have been relieved by maintaining the ovary in its proper place, or by removing it.

Trouble is especially liable to occur when the ovary is enlarged to the size of an orange or even less. In such a case removal by operation is clearly indicated. The influence of disease of the ovaries is not less remarkable.

Do we not see in these facts proof that these organs exercise a motor and governing power over the nervous centres. It seems more rational to look for freedom from mental disease in those women who have undergone a successful operation for the cure of an ovarian or uterine disease. Such diseases we know are apt to entail nervous disorders, and we have seen that the nervous disorders, when complicating disease of the sexual organs, are frequently cured when the diseased organs are removed."

Dr. Savage reports a case in which profound melancholy was associated with prolapsus of the uterus, and the patient had been restored to health within twenty-four hours of the relief of the conditions. Dr. Bantock reports the case of a woman who for nine years had been the subject of a form of melancholia. She had tried every kind of treatment until she came under the notice of Dr. Marion Sims, who after examination at once said he thought the patient could be cured. She was taken to Europe and Dr. Bantock confirmed the opinion of Dr. Sims, and an operation

was agreed upon. It was performed by Dr. Bantock and revealed "the ovaries in that peculiar condition which resembled a deformed bunch of grapes, very little larger than the normal, they were evidently extensively diseased. Within two months the patient was quite restored to health, and she had remained well ever since. There the connection between the ovarian lesion and the mental disturbance was clear and indisputable."

Dr. R. T. Smith, an English surgeon of unquestioned ability, in reporting a case where he had removed the ovaries says: "In the whole round of the various kinds of treatment which need to be adopted for the diseases which come under our notice as gynecologists, there is none which causes more thoughtful and anxious consideration than the use of surgical procedures for nervous disorders. From this case we may deduce this lesson, that while hysteria is frequently a disease that may be safely left to moral and general treatment, it is also sometimes a very serious disease in itself, and demands energetic and indeed surgical interferences."

Dr. Barnes in discussing this case "inquired whether the cases reported by Gull, Fagge and others, of hysteria without local disease, had been examined in the presence of a gynecologist; otherwise he would demur to accepting those cases as proof that hysteria could arise independently of pelvic disorder, when properly treated by local measures hysteria often disappeared. The statement that such cases often required surgical treatment was full of truth and hope."

Dr. Bantock in referring to Dr. Smith's case said: "He did not know that it was necessary to justify the operation that they should have very distinct evidence of disease in the ovaries, what they regarded was the association of these attacks with some condition of the pelvic organs and particularly of some association with the menstrual function."

Dr. Bucknell: "There can be no doubt that uterine disorder constitutes one of the most frequent remote causes of insanity with which we are acquainted. Dr. Esquierol: "Menstrual anomalies make up a sixth part of the causes of insanity, "Dr. O. G. Pfaff reports a case of insanity

cured by removal of double pyo-salpinx, patient returned to her home in a month and continued to improve until cured.

Among American physicians and surgeons who have taken advanced ground on this subject, energetic, progressive men who are not in bivouac or barrack but on the march we are glad to name Dr. George H. Rohe, Dr. I. S. Stone and Dr. C. A. S. Reed.

Dr. Rohe says: "Every gynecologist has had within his own experience cases of neurosis, persistent pain, psychical depression not amounting to melancholia, "nervousness," hysterical manifestations, etc., which he has found to depend upon some lesion in the pelvic organs. I venture to say that no form of treatment gave such prompt results in these cases as the surgical, whether that consisted in the ablation of the uterine appendages, extirpation of the uterus, the repair of cervical lacerations, or the restoration of a ruptured perineum. At all events, I do not hesitate to say that this has been my own experience with women outside of an insane hospital."

In a personal communication under date "of January 24th, 1893, Dr. Rohe writes:—So far as my abdominal cases are concerned I have now done 22 sections here—20 with removal of the appendages and two exploratory. Four of the cases have been discharged recovered and are still well. One other is so much improved that she has been given leave of absence and has now been at home over three months. I hear from her regularly and judging from the reports I receive I will soon be able to discharge her also. Two of the cases (epileptics) died, one from septicemia,—a large collection of abscesses in the ovaries and tubes,—and one other also from septicemia, although death occurred in status epilepticus. None of the cases have been made worse. In nearly all there has been mental improvement. In all there is physical improvement. This would naturally be expected as the operation was nearly always done for sufficient physical disease to demand it irrespective of the mental condition. I observe that Dr. Alice Bennett has been interfered with in her work at Norristown. I regard that as a great outrage, and hope the profession in your

State will express itself in positive tones upon this system of regulating the practice of medicine."

Dr. I. S. Stone makes the very pertinent inquiry: "Can the Gynecologist aid the Alienist in Institutions for the Insane? This question, he says, should receive an affirmative answer without debate. The question is asked by the Gynecologist briefly thus: Are there not in every community of from one hundred to five hundred, many cases of uterine or pelvic disease? Is it not true that in a community of five hundred sick women, sick mentally often because of bodily infirmity, that the statement should be doubly true? We claim that very many more pelvic causes of insanity exist than are found, owing to the difficulty of making a diagnosis in these cases. No fact is better understood than that any disease of the abdominal organs may favor insanity even by interference with nutrition alone. How much more does it seem probable that disease of the organs peculiar to women, which so much more than the corresponding organs in men, have to do with her physical and mental condition, may cause psychical derangement."

Dr. C. A. L. Reed speaks plainly and gives the conclusions of a student of the subject in all its bearings:

"A gynecologist has at last been appointed the medical officer of a hospital for the insane. He has dispelled several illusions which have been imposed upon the profession and the community by the old and, unfortunately, yet existing *regime*. In the first place, he has found that these patients can be examined without injury to themselves; in the next, that diseases of the intrapelvic organs can be as readily diagnosed in their cases as in others; that they can be operated upon as readily and with as good results as sane patients; and, finally, that after primary recovery from abdominal section, a very encouraging proportion of them recover mentally; and, still lastly, that among the most happy mental recoveries are cases that have been incarcerated for years and labeled as incurable. I invite the attention of the profession to the magnificent work being done in this direction by Dr. George



H. Rohe, of the Maryland Hospital for the Insane. When asylums become organized as hospitals, with staffs as specialists in the various departments in attendance, we shall realize the maximum of recoveries in these institutions."

The frequent association of hysteria with disease of the appendages is generally admitted. Yet it is not maintained that there should be resort to surgical procedure in every case of hysteria. There should be clear indications, a recognized association of mental disease with sexual disorder.

Some of our best authorities doubt the existence of hysteria independent of pelvic disorder. In a discussion before the College of Physicians, December 4, 1889, Dr. S. Weir Mitchell said he "agreed with Dr. Price in regard to this operation in hysterical women. Many who had both ovaries removed and were none the better for it, seemed to constitute the most irremedial of all the cases of hysteria. There is one condition which makes it justifiable to operate on healthy ovaries. That is where a woman, passed the age of probable marriage, is insane only at the menstrual period. In two such cases removal of the ovaries was done at his request by Dr. Goodell. One was a case of homicidal mania at the menstrual periods, and the other case was one in which were developed extraordinary sexual appetites in a woman at other times modest. In both of these cases the recovery was absolute."

Dr. Marie B. Werner, a specialist and skillful diagnostician, made a series of examinations of patients in the Norristown Asylum during the Spring of 1892, and her careful summary (MEDICAL AND SURGICAL REPORTER, Dec. 31, 1892,) of what she found in thirty cases has great value as giving in succinct form an analysis of the many and varied troubles she encountered, with brief reference to their history, where such could be obtained:

CASE I. Melancholia, following last labor, vagina examined; *small mass in right pelvic space; prolapsus of uterus; lacerations of cervix and perineum.*

CASE II. Acute Melancholia. First attack supposed to have been induced by the establishment of puberty; second at-

tack followed third labor; *uterus fixed posteriorly; mass to the left; right ovary prolapsed.*

CASE III. Acute Mania. Attack sudden, in August, 1891; patient aged forty-seven; vagina examined; uterus drawn to the left; *painful mass on right side; cyst of right labia; complains of pain down legs when walking.*

CASE IV. Melancholia. Second attack, vagina examined; uterus anteflexed; *masses both sides.*

CASE V. Mania. Vagina examined; uterus retroverted and fixed; body large, cervix small; rectal examination reveals *masses on both sides.*

CASE VI. Melancholia. Three months after birth of child. *Uterus retroverted and fixed; external hæmorrhoids.*

CASE VII. Melancholia. Uterus enlarged, *fixed to the left; mass on right side; cystic degeneration of cervix.*

CASE VIII. Mania. Multinodular Uterus; *masses on the right side* with tenderness; cystic degeneration of cervix, and bleeds to touch.

CASE IX. Mania. Uterus enlarged; some *impaired mobility; cervix cystic and eroded.*

CASE X. Mania. Last labor occurred six months before admission. *Uterus enlarged, somewhat hard; moderately movable; cervix patulous; bleeds readily.*

CASE XI. Chronic Mania. Brain fever marked the onset of the attack; *uterus retroverted, prolapsed and fixed; tenderness in both pelvic spaces.*

CASE XII. Mania. - *Mass in right pelvic space; perineum lacerated.*

CASE XIII. Melancholia. "Was not well after last child was born." *Uterus prolapsed; laceration of cervix and perineum.*

CASE XIV. Mania. Second attack; *uterus fixed, masses on each side; laceration of cervix and perineum; kraurosis of both vaginal orifice and vulva.*

CASE XV. Mania. *Small undeveloped uterus; fundus posterior and to the left; moderately movable.*

CASE XVI. Mania. Last child July 20, 1891; placed in Friend's Asylum, August 8, 1891; uterus fixed anteriorly; *tubes tortuous and enlarged; left ovary*

*cystic*; laceration of both cervix and perineum; varicose veins at vulva orifice.

CASE XVII. Imbecility. Three children; last, four and a-half years before attack; *uterus fixed posteriorly; masses on both sides*; cervix patulous and lacerated; also perineum; hæmorrhoids.

CASE XVIII. Mania. Last labor thirteen months before attack, which was gradual in onset; uterus and appendages normal; marked lateral tear of vaginal wall nearly to cervical junction, causing prolapsus.

CASE XIX. Melancholia. Onset four months after last labor; uterus prolapsed and retroflexed; *mass in left pelvic space*; movable body in right pelvic space, like the ovary.

CASE XX. Chronic Mania. Uterus atrophied; *laceration of cervix and perineum*; some cicatricial bands in vagina.

CASE XXI. Second attack. Atrophy of uterus; pelvic spaces free; some *laceration of perineum*.

CASE XXII. Melancholia. Third attack. Ante flexed enlarged, but movable uterus.

CASE XXIII. Second attack. Anteverted uterus drawn to left; *mass to the right*.

CASE XXIV. Melancholia. Cause puerperal; uterus enlarged and prolapsed; *mass on the left*; lacerated perineum; external hæmorrhoids.

CASE XXV. Chronic mania. Cause puerperal; uterus fixed anteriorly, cervix large, body small and flabby. *Tender masses in both lateral spaces*; old fistulous tract to the right of the anus extending directly upward beyond the internal sphincter.

CASE XXVI. Acute mania. Second attack. Ante flexed uterus; engorged cervix and vagina; *mass on right side*.

CASE XXVIII. Chronic mania. pelvis of male type; vagina short; uterus undeveloped, fundus backward; cannot distinguish the appendages.

CASE XXIX. Mania. Fourth attack. Vaginal examination, *uterus fixed posteriorly, tender mass on left side*. Section July 3rd, 1892, removed appendages; cystoma of left ovary; right ovary undergoing calcareous degeneration; both tubes undergoing tubercular degeneration,

there were some adhesions from a recent peritonitis. Patient made a rapid and uninterrupted recovery; was discharged cured five weeks after the operation.

CASE XXX. Acute dementia. Admitted 1888; vaginal examination; enlarged anteverted uterus; *mass on right side distinct*; complains of *great tenderness in left side which feels boggy*. Section, July 3rd, 1892; removed appendages; hydro-salpinx of both sides; left tube degenerated to a large cyst; dense adhesions to bowel, uterus and posterior cul-de-sac. On right side tube somewhat smaller, but tortuous, fimbriae of both obliterated. Used drainage thirty hours; patient made a good recovery, which I understand also includes marked mental improvement.

Dr. Werner, in discussing in these cases, says: "Some operators, who have successfully dealt with multiple and single abscesses in the pelvic structures, which had given rise to periodic attacks of pelvic peritonitis and in consequence to vicious adhesions which alone often give rise to the most painful symptoms, have extended their influence and knowledge in the direction of that class of unfortunate, who often cannot understand or make known their suffering, viz., the insane. Their results have on the whole been encouraging, in so far that they have removed one source of irritation, always having in mind to operate only in cases where disease can be demonstrated beyond a doubt.

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These cases have made me feel that there is a necessity for careful study of all cases, and especially those in which the puerperal period antedates an attack. If a remote irritation can lead to insanity or epilepsy, why cannot an abscess, tubercular disease or other pelvic inflammations, also enter the field as causative factors? The claim is not to cure by operation, but by removing the irritation and thus aiding nature in restoring gradually, perhaps, its lost nerve force.

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It is impossible for the alienist to be a specialist in all branches of medicine; and it is a fact, that the insane are subject to all the diseases the sane are troubled

with; hence the necessity for special work in special directions. This work however should be a conscientious painstaking study of each individual case."

These are of a number of cases to which the State Lunacy Commission, by the advice of their *learned* counsellor, object to being surgically treated.

As to the legal inquiry—are we justified in operating on a lunatic who cannot give a responsible assent? Sir Spencer Wells, in one of these cases, consulted Sir William Harcourt, then Home Secretary of England, as to the legality of ovariectomy upon a lunatic. The Home Secretary said: "If she is incapable of judgment for herself, treat her as if she were an infant." So the operation was done, the patient recovered and married. This dictum, full of the very meat of good sense, given out by one of the highest authorities of England, whence I believe we have copied the most that is best in American law, should certainly not be set aside though it be in conflict with the opinion of the astute Attorney of the Lunacy Commission. Were some member of a lawyer's family affected with some hereditary mental disturbance combined with some pelvic trouble decisively indicating surgical treatment, there would be no question raised as to the legality of the procedure to remove diseased parts.

Women come to us in great numbers for the relief of disorders of the sexual organs. They come because they suffer; we surgically interfere to relieve their suffering. The insane suffer fully as much as do the sane; they are equally entitled to attention, and it is as much a

duty to relieve their misery as that of the sane. The treatment of such diseases might, as expressed by Dr. Barnes, often be undertaken quite independent of any idea of curing the mental condition, but simply for the purpose of relieving physical distress.

The State, having taken these people under its protection, pledges every provision for their welfare, every means and agency of relief in the way of shelter, home care, nursing and every needed medical and surgical treatment. The insane are as strongly predisposed to uterine and pelvic troubles as are the sane, and there can be no other rational conclusion than that the results of surgical treatment would be as fortunate, from a surgical standpoint, in one class of cases as in the other. In sane cases general practitioners are alive to the importance of consultations with specialists in all cases of pelvic and uterine disease. Why the same importance of consultations does not exist in an insane case it would be difficult to explain.

The time will come, and it is to be hoped for the sake of suffering women it is not far distant, when an enlightened public sentiment will demand the opening of asylum doors to the free ingress of every agency that can cure or in any form mitigate the suffering, or make better the condition of the insane; when our asylums will not only be in charge of excellent physicians; but with skilled gynecologists and thoroughly trained and expert professional nurses,—those with a training specially adapting them to their work.